DOCUMENT RESUME

ED 261 291 CG 018 489

TITLE	Health Maintenance Organizations and the Elderly: Promises, Problems, and Prospects. Hearing before the Select Committee on Aging. House of Representatives, Ninety-Eighth Congress, Second Session (Boca Raton, Florida).
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
PUB DATE	9 Jul 84
NOTE	120p.; Some pages are marginally reproducible due to small print.
PUB TYPE	Legal/Legislative/Regulatory Materials (090) -- Reports - Descriptive (141)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Delivery Systems; *Health Insurance; Hearings; *Older Adults; Program Descriptions; Quality Control; *State Standards
IDENTIFIERS	Congress 98th; Florida; *Health Maintenance Organizations

ABSTRACT

This document contains the transcripts of witness testimony and prepared statements from the Congressional hearing called to explore the impact of the Health Maintenance Organization (HMO) on the health care system and on the elderly in particular. Opening statements are given from Representatives Dan Mica, Matthew Rinaldo, and Lawrence Smith. Testimony is presented from two panels of witnesses. The first panel consists of four Florida citizens who are members of HMO's and who represent the consumer's viewpoint. Also included on panel one are representatives of the Florida Insurance Commission and the Department of Health and Human Services. The second panel of HMO providers includes the president, Doctor's Office, Incorporated; the executive director, Group Health Association of America; the senior vice president for medical affairs, International Medical Centers; the director of administration, Av-Med, Incorporated; and the president and past president of two Florida county medical societies. Additional, brief testimony is included from 25 audience participants. Topics covered include the nature and kinds of problems associated with alternative health care programs including the need for: regulation of HMO's, assurance of quality care, and review of the enrollment and disenrollment process. The appendix contains additional material submitted for the record. (MCF)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

HEALTH MAINTENANCE ORGANIZATIONS AND THE ELDERLY: PROMISES, PROBLEMS, AND PROSPECTS

ED261291

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

JULY 9, 1984, BOCA RATON, FL

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 98-469

CG 018489

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

U.S. GOVERNMENT PRINTING OFFICE

39-042 O

WASHINGTON : 1984

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
IKE ANDREWS, North Carolina
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
GERALDINE A. FERRARO, New York
BEVERLY B. BYRON, Maryland
WILLIAM R. RATCHFORD, Connecticut
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
DONALD JOSEPH ALBOSTA, Michigan
GEO. W. CROCKETT, JR., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
FREDERICK C. (RICK) BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
TOM VANDERGRIFF, Texas
ROBERT E. WISE, JR., West Virginia
BILL RICHARDSON, New Mexico

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
JUDD GREGG, New Hampshire
GEORGE C. WORTLEY, New York
HAL DAUB, Nebraska
LARRY E. CRAIG, Idaho
COOPER EVANS, Iowa
JIM COURTER, New Jersey
LYLE WILLIAMS, Ohio
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
MICHAEL BILIRAKIS, Florida
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
MICHAEL DeWINE, Ohio

JORGE J. LAMBRINOS, *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

CONTENTS

Members' Opening Statements

	Page
Dan Mica	1
Matthew J. Rinaldo	4
Lawrence J. Smith	5

Chronological List of Witnesses

Panel one—HMO's and consumers:	
Claude D'Angio, chairman of the Citizens Advisory Board to International Medical Centers for Palm Beach County, FL	8
Murray Levine, Greenacres City, FL	10
Mori Freemon, Hollywood, FL	28
David Custage	33
Clyde Galloway, Jr., chief of Bureau of Allied Line, Florida Insurance Commission	36
Wayne Fowler, director, group health plan operations staff, Bureau of Program Operations, Department of Health and Human Services	39
Panel two—HMO's and providers:	
Frank Colavecchio, president, Doctor's Office, Inc	51
James Doherty, executive director, Group Health Association of America	53
Dr. Jay Sanders, senior vice president for medical affairs, International Medical Centers	60
Jonathan Rose, director of administration, Av-Med, Inc	67
Dr. Ernest Sayfie, past president, Broward County Medical Society	69
Dr. Lee Fischer, president, Palm Beach County Medical Society	73

Audience Participants

Ignactious DeGuardia, Deerfield, FL	90
Natalie Seligson	90
Ben Stulberger	90
Sharon Johnson	90
Harry Winnecker, West Babylon, FL	91
Paul Ross, Lauderdale Lakes, FL	91
John Moas, Lake Worth, FL	91
Rodney Dorset	91
Ruth Cohen, West Palm Beach, FL	92
Fernando Soto	92
Max Sukker	93
Harvey Cohen	93
Harvey Birnbaum, Lake Worth, FL	93
Barbara Muller, Tampa, FL	94
Herbert Warren	94
Esther Wolinsky, Lake Worth, FL	94
Minnie Friedlander, Boca Raton, FL	95
Ethel Sitzman, Boca Raton, FL	95
Woody Wood	95
Albert Whitehall	96
Pete Tedesco, Boynton Beach, FL	97
Frederick Frolich	97
John Wood	97
Anthony Nardiello	97
Sam Shaksby, Delray Beach, FL	98

APPENDIX

Additional material received for the record:	Page
David Custage, Highland Beach, FL, letter	101
Samuel D. Gordon, Boca Raton, FL, letter	101
Robert L. Kennedy, FACHA administrator, North Broward Hospital, Pompano Beach, FL, letter and attachments	102
Sam Lichman, Delray Beach, FL, letter	106
Anthony Nardiello, Coral Springs, FL, letter	107
Robert F. Pickett, president, Best Buy Drugs, Inc., West Palm Beach, FL, letter	109
Seymour R. Rosen, M.D., Sunrise, FL, letter	110
David R. Vreeland, M.A., West Palm Beach, FL, letter	112
Edith Wagner, Hollywood, FL, letter and attachments	112
Albert V. Whitehall, Lake Worth, FL, letter	115

HEALTH MAINTENANCE ORGANIZATIONS AND THE ELDERLY: PROMISES, PROBLEMS, AND PROSPECTS

MONDAY, JULY 9, 1984

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Boca Raton, FL.

The committee met, pursuant to notice at 9:30 a.m., in the Gold Coast Room, Florida Atlantic University, Boca Raton, FL, Hon. Dan Mica (acting chairman of the committee) presiding.

Members present: Representatives Mica of Florida, Rinaldo of New Jersey, and Lawrence Smith of Florida.

Staff present: Gary Christopherson, professional staff, and Paul Schlegel, minority staff director, of the Select Commmittee on Aging.

OPENING STATEMENT OF REPRESENTATIVE DAN MICA

Mr. MICA. The select committee will please come to order.

I'd like to just take a moment here and welcome everyone in this hearing. I am truly surprised by the number and the turnout; but I must say, I should have expected it.

My congressional office has literally been inundated with questions and comments about HMO's over the last few months, and that's one of the reasons why I tried to schedule this hearing.

As you may know, this hearing was originally scheduled in May, due to an unforeseen session on that day, of Congress, we had to reschedule it for today.

I'm very pleased that we have with us today, the ranking Republican on the Aging Committee, Congressman Matt Rinaldo of New Jersey. We welcome you to Florida.

And, also, another Floridian, a member of Foreign Affairs Committee, I might add, Congressman Larry Smith of south Florida, Broward, and Dade County.

We appreciate having you here today.

Let me just start before I read my formal statement, by saying this——

Ms. FREMON. What's your first name?

Mr. MICA. I'm Dan Mica.

While I'm doing that, I might also introduce some staff members from the Aging Committee: Gary Christopherson, where's Gary, over here.

A VOICE. Stand up, so we can see him

Mr. MICA. Stand up, Gary.

And Paul Schlegel from the minority side.

We appreciate them making all of these arrangements. Believe me, that's a special and very difficult job in and of itself, that takes place long before we ever get here.

The first and foremost question that's asked about HMO's, and in fact why we're having these hearings, I think I need to answer for you today. There is a great deal of misunderstanding. We've tried to send you information. You've called our office, and other offices here in Florida. Every Congressman in south Florida has been inundated.

HMO, Health Maintenance Organizations, in and of themselves, are not good or bad. A Health Maintenance Organization is a way to deliver health service, health care if you will.

There are 335 operational HMO's in the United States; 208 federally qualified HMO's, as of July 1; 14.2 million people enrolled in HMO's; 60 demonstration projects. In Florida, there are 17 operational HMO's, a number of pending requests; 10 federally qualified HMO's; 352.2 thousand people enrolled in HMO's, and 5 demonstration projects. Their revenues have grown from 1979, from $166 million to over $350 million in 1982, and we don't have statistics for 1983 and 1984. Their assets have grown from $367 million to nearly $800 million.

So, suffice it to say, like a doctor, a doctor is neither good or bad. It depends on the individual, the training and the care.

A hospital is neither good or bad. It depends on many factors.

An outpatient clinic is neither good or bad.

And, an HMO, in and of itself, is neither good or bad. We've had some great ones in this Nation, and we've had some that were outright improperly run and folded.

We are here today to talk about the projects in south Florida, and this prefaces a move by the Federal Government in Washington to say, in effect, to the rest of the Nation, that as we look at HMO's we may or may not recommend that every part of the Nation get involved and start enrolling in HMO's.

The Secretary of Health and Human Services has already, in some individual's minds, jumped the gun by saying that maybe we should move rapidly into HMO's nationwide.

What we hear in this hearing, what you provide to us today, what other hearings like this around the Nation bring to us, will be made a part of the record, so that we can better make that decision as to how much of this Nation should be pushed or cajoled or warned about HMO's.

We're simply here to hear the pros and cons. We will not pass any legislation today. We will do a report on this hearing. We will take testimony. We have done our very best to bring witnesses, both pro and con before us here today.

With that, I'd like to just ask my colleagues for permission to insert in the record my prepared statement which I didn't read for this hearing. I will call on the ranking Republican member, and senior member from the minority side, Matt Rinaldo, for any opening comments.

[The prepared statement of Representative Dan Mica follows:]

PREPARED STATEMENT OF REPRESENTATIVE DAN MICA

I want to welcome my colleagues Congressman Matthew Rinaldo, Ranking Member of the House Aging Committee, and Congressman Larry Smith from our neighboring 16th Congressional District to Boca Raton today. These two Members of Congress are ideally suited to participate in this hearing on Health Maintenance Organizations. Matt Rinaldo has worked on aging issues for over 12 years and has proven himself an able and dedicated advacate for older Americans. Congressman Smith has taken an active interest in HMOs and particularly South Florida Demonstration projects.

Our joint purpose is very clear: To begin an exploration of the impact of the Health Maintenance Organization on our Health care system and, particularly, on the elderly of this nation. Today's hearing is the first of its kind in this country, and may lead to additional hearings on a national level. The knowledge, experience and insight shared here today may well affect the future direction of health care in our communities. The time has come to examine and evaluate the impact of a dramatic new health care concept on the lives of those it's intended to serve.

This hearing is the culmination of my long interest and work on health care concerns of the elderly in our area. My predecessor, Congressman Paul Rogers, known throughout the Congress as "Mr. Health", introduced the founding HMO legislation over 10 years ago, so I am aware of the potential benefits. As soon as I was elected to Congress, I requested a seat on the Aging Committee so that I could in someway continue to address the health needs of our seniors.

I have an abiding interest in the success of HMOs that may prove to be part of the solution to the high cost of health care in this nation. But I also have concerns about the rapid growth in numbers of HMOs, the marketing techniques used to enroll new members, the current status of oversight and regulation of HMOs, and the quality of health care provided through this new health care delivery system.

I know you have great interest in this subject as well. The public interest and need to know first surfaced at Town Hall Meetings throughout our District last year. My office was flooded with phone calls and letters asking for information and advice about HMOs. Few issues have provoked more mail or calls to my office than this one. In an effort to respond to your concerns and to provide some guidelines useful in choosing health care options to meet your needs, my office first distributed a fact sheet on HMOs to those who specifically requested information. As the interest continued to grow, we provided an HMO fact sheet to all District residents. And, finally, I requested the Chairman of the Aging Committee to call for this fact-finding hearing.

As you may know, this local interest has been mirrored on the national level. According to the Bureau of Health Maintenance Organizations, the fact is that today there are 335 operational HMOs serving 14.2 million people nationwide. In Florida alone we have 17 working HMOs serving over 350,000 people, including five demonstration projects. The fact is that HMO revenues grew from $166 million in 1979 to over $346 million in 1982 and that HMO assets grew from $367 million in 1979 to $764 million in 1982. Any business that grows so dynamically in such a short period requires close examination.

This hearing is very timely. Secretary of HHS Margaret Heckler recently announced new regulations allowing over 30 million Medicare beneficiaries the option of signing up with HMOs. It is our hope that the information gathered here today will be useful in evaluating this expansion of HMO services to the elderly.

It is fitting that this first hearing on HMOs and the elderly should be held in the state of Florida where one of every six people is over the age of 65. Today, over 1,800,000 Floridians are over 65. By 1995, the figure will exceed 2,500,000.

As our senior citizens get older, they begin to constitute the fastest growing segment of our population: 75 plus. The health care needs of the advanced elderly are even more challenging than their younger counterparts. Any valuable discussion of health care alternatives must address this burgeoning group.

We in Florida have the highest percentage of older people of any state: 18.1%. It is no wonder that the rest of the nation is watching us to see how we respond to the health care challenge. It is no wonder that the HMO concept must receive its first close scrutiny here in our state.

I want to welcome our two panels of speakers and all of you who have taken the time to join us today. I appreciate the interest you have shown in this vital subject, and I hope we can work together to provide fair and equitable health care solutions for all Americans.

STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. RINALDO. Thank you very much, Mr. Chairman.

First of all, I want to commend you for holding this hearing, and inviting me to join you on a very vital health care topic, and I think you did an excellent job in summarizing the situation in Florida and in this Nation.

Health Maintenance Organizations, or HMO's, as they are commonly known, are quickly becoming a permanent part of our Nation's health care delivery system.

Just a few weeks ago, a private health research and education center, based in Minnesota, pointed out that enrollment in HMO's in the last 6 months of 1983 rose by 9 percent, reaching 13.6 million individuals in December 1983. If that pace continues, the growth rate would break all previous HMO enrollment growth records.

I can state for the record, that in my own State of New Jersey, over 200,000 people have enrolled in 10 HMO's, one of which is located in Princeton, NJ, which I represent in Congress.

I understand that the number of medicare enrollees is approximately 2,000 throughout my State.

In my opinion, I think the rapid growth and escalation of HMO's is closely related to health care costs, which are continuing to rise at twice the rate of inflation in the general economy, and people, especially the elderly, desperately need and deserve full coverage for their health care needs.

HMO's provide one avenue of hope. I think it's true to say that the traditional health care system has driven people to find more affordable and more comprehensive ways of receiving their health care.

With that in mind, I think the members of this committee have a very substantial responsibility to America's senior citizens to insure that the HMO system, which despite its rapid growth, is just now beginning to take shape, is responsible, responsive, and certainly that the people running it are dedicated to the needs of the elderly.

I noted with interest, Mr. Chairman, the material submitted by Dr. Fischer, from the Palm Beach County Medical Society, in which he goes into detail about some of the problems of HMO's in this area.

I am looking forward to listening to his testimony, and to the testimony of our other witnesses, who will point out some of the positive aspects of HMO's.

In conclusion, Mr. Chairman, I want to thank you once again for scheduling this hearing. I think it's obvious, by the turnout, the number of people who have come here, of the interest in this issue. I might mention parenthetically, that we've had hearings on various topics all over the country, and in all the years I've been on the committee, and I've been on it since it practically started, I don't know of one hearing anywhere in the United States that attracted a crowd as large as this one. I think it's because this is an important topic, and one the committee will look at very closely when we return to Washington.

I have no doubt that the testimony that we receive today will play a key role in any kind of action that we take, and will help us in considering legislation in the House of Representatives.

I am pleased to be here, and look forward to hearing from our witnesses.

Mr. MICA. Thank you kindly, Mr. Rinaldo. Now, I'd like to call on our other Florida Congressman, Congressman Larry Smith.

STATEMENT OF LAWRENCE J. SMITH

Mr. SMITH. Thank you, Dan. Thank you, everyone.

I want to thank Congressman Mica for allowing me to sit in today. One minor correction, I'm not a member of the Aging Committee; I am very interested, however, since my constituency in Broward County is very similar to the one here in Palm Beach. We are as concerned in my district as you are in Palm Beach, and some of you here are from Broward, about the fact that there are major problems of medical cost to, not only senior citizens, but the whole population of the United States. HMO's may be a very valid way of providing medical care, but there may be many problems associated with this, like there have been over the years with different other forms of medical provision.

As a result, I'm very happy that this hearing has been scheduled for today to continue to look into the relationship of HMO's providing medical care, and the costs associated therewith.

Obviously,the Federal Government, as well as all of your Congressmen, are interested, and I think that all providers of medical care are interested in providing quality health care, at the lowest cost possible to the consumer.

From our point of view, when it comes to medicare beneficiaries should receive quality medical care, to medicare beneficiaries at the lowest cost to the Federal Government.

We're all aware of the problems that medicare is facing down the road, and HMO's are one way that we will be going to be able to deliver quality care and save the system, to some degree, because of the large output of dollars.

I also want to thank the members of the House Aging Committee for permitting me to participate in this hearing, because I think that it's very important that all of you realize that there are ongoing hearings, constantly being taken in Washington to measure, to gauge the success of the law which allows for HMO's to deliver health care to medicare beneficiaries. Not every HMO is now permitted to participate. I think you ought to understand that is only by virtue of demonstration projects, which have been set up by the Federal Government, with certain HMO's that we are involved in providing health care through HMO's to medicare beneficiaries.

As many of you may know, I requested a General Accounting Office review of this program, that is, the Demonstration Project Program, on January 30 of this year, because of the numerous questions and some complaints brought to my office and the office of other members, especially, in this area.

The population of Florida is considered to be a bellwether population by aging experts. The heavy consumer interest in these dem-

onstration projects, in Florida, shows the kind of interest we can expect, as this program is put on line nationally.

After 2 years of inaction, the administration has chosen now to move ahead with this program and make it available nationally. This is being done before the information from the demonstration projects can be properly analyzed, and before the GAO Review can be completed. The GAO has told me that this review is the single most important project in the health field that the GAO currently is undertaking.

It's very important to remember that this demonstration project is limited to certain areas in the United States, with this area being the largest, because in many other places there are no availability of HMO's for medicare service provisions.

No medicare recipient can go into one, for instance, in Maine, and register because no project is available there.

Now, we are having a GAO review done, and this demonstration project is supposed to reveal statistics. Now the rules and regulations are being written, so, nationwide, all HMO's will open up before we know what the statistics here in Florida have to say about the ultimate value of the program, and the way the Federal Government can overview it.

I think it's very important that we understand that the Federal Government needs to overview these projects.

HMO's may be the only means by which we can provide additional services to the medicare population without further eroding the financial integrity of the system.

If we are to forge ahead with this program, I, and many of my colleagues would like to see this program administered correctly. Let me tell you, as many complaints come into my office, about the Federal Government bureaucracy, and the system by which this HMO demonstration project is being administered, as there may be in the HMO Provision of Services, and I would be the first to tell you that I think that the Health Care Financing Agency, some of you may know it as HCFA, has a long way to go in dealing with the problems that are attendant with the rapid growth of HMO's and provision of medicare service to the elderly.

So, it's not just HMO's themselves, in this instance that we want to hear about. Frankly, I'm interested in how the Federal Government overviews the whole project in its inception through its delivery, and out into the long term, and whether we're ready, since there are approximately 26 million available beneficiaries that could come on the system; how we're going to monitor any system that goes nationwide before we know what we have just locally with the 120-some-odd thousand that are registered in Florida with HMO's to provide medicare service.

Many of us in Congress, like you, are still learning about HMO's and their impact on medicare beneficiaries, and the community at large.

I hope that this hearing can provide us with the information so that we in Congress can better evaluate the current demonstration project, and expand the program in an orderly and efficient system, as I said, to ultimately provide quality medical care at the lowest cost possible.

Quality medical care, because that's the least that you all deserve, and at the lowest cost possible, because again, as taxpayers, that is in the very least that we should be paying.

So, I hope that these hearings will provide us with this information. I'm sure that this is one of a number of hearings that are going to be scheduled, and I, like my fellow Congressmen here, appreciate very much your turning out today.

I can tell you that it is, as Congressman Mica has indicated, a very, very good turnout; and I'm sure that's a tribute, not only to the subject, but also to the gentleman who represents you here in Palm Beach County.

Mr. MICA. Thank you very much, Larry.

We're going to proceed with our panel, but just one brief comment.

We will have a panel of HMO's and Consumers. Consumers, the people who are members of HMO's.

We will have a panel of providers, people who give the service, and after that we will take 1 minute speeches from the audience at the end of the hearing.

Now, it's obvious, I hope it's obvious to all of you if you look around, if we tried to take a 1 minute speech from everyone in the audience, it would be absolutely impossible.

I do recognize that each of my colleagues have other commitments, so at about 12:30, which would allow us possibly 20 or 30 1-minute speeches, we will have to stop the hearing.

Now, I don't want anyone to say at 12:30 that we have stopped that because we didn't want to hear them. We want to hear everybody, so I'm announcing it early. We intend to have these hearings.

Let me present one other point, if you want to submit a letter or a statement in writing, as a 1-minute speech, we will see that it's included in the record, so no one will be precluded.

I recall another hearing I attended, where when we had to stop it, that one individual was convinced that he was the one we didn't want to hear.

We want to hear everybody; we're going to be as liberal as we can in trying to have these individuals come up one 1 minute a time and give us a little comment.

With that, we'll proceed with our first panel, and we'll ask the panel, if we may, to summarize as much as possible, so that we can get into a little give and take.

That first panel is made up of Consumers: Claude D'Agnio, Murray Levine, David Custage and Mori Fremon.

Also, I see the other witnesses, Mr. Galloway, Clyde Galloway, from the Insurance Commission Office, is, oh, you are here. How about Mr. Fowler?

Mr. Fowler is the director of Health Plan Operations for Health Care Financing Administration, also here at the table.

We'll start right down here, in this order, right across the table, with Mr. D'Angio.

Mr. D'ANGIO. Thank you.

Mr. MICA. Please proceed, and welcome to the committee.

PANEL ONE: HMO'S AND CONSUMERS, CONSISTING OF CLAUDE D'ANGIO, CHAIRMAN OF THE CITIZENS ADVISORY BOARD TO INTERNATIONAL MEDICAL CENTERS FOR PALM BEACH COUNTY, FL; MURRAY LEVINE, GREENACRES CITY, FL; MORI FREEMON, HOLLYWOOD, FL; DAVID CUSTAGE; CLYDE GALLOWAY, JR., CHIEF OF BUREAU OF ALLIED LINE, FLORIDA INSURANCE COMMISSION; AND WAYNE FOWLER, DIRECTOR, GROUP HEALTH PLAN OPERATIONS STAFF, BUREAU OF PROGRAM OPERATIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES.

STATEMENT OF CLAUDE D'ANGIO

Mr. D'ANGIO. I am Claude D'Angio, chairman of the Citizens Advisory Board of International Medical Centers for Palm Beach County. I am also a member of the Gold Plus Plan. I am a retired organic chemist with more than 35 years experience in research, administration and consultation. I want to thank this committee and Congressman Mica for giving me the opportunity to testify today.

I believe the Medicare HMO Program is the best thing that's happened to senior citizens since the beginning of medicare in 1965. Prior to the establishment of the Demonstration HMO Program, many senior citizens could not afford the medical care they needed. Unable to pay the ever-increasing premiums for supplementary health insurance, they did without, rather than go into debt. As you know, medicare covers less than 60 percent of actual doctor's fees in this part of Florida. Also, Medicare does not cover the cost of prescription drugs, eye examinations, dental treatment, et cetera. Under the Gold Plus Plan, senior citizens are receiving comprehensive medical care. In addition, they get free prescription drugs, eye glasses, routine dental care, and hearing aids. A most important benefit is that senior citizens do not pay anything for in-hospital care regardless of length of stay. Under medicare, they would be required to pay the first $356 and would be limited to the first 60 days for benefit payments.

The HMO Program is not suitable for all medicare cardholders. Specifically, senior citizens who live in this area only part time, and who spend more than 3 months away from their Florida residence, would be better off with the regular Medicare Program. Although the Gold Plus Plan will reimburse a member for care received outside the treatment area, when such medical care is either an emergency or urgently needed care. Urgently needed care is for a condition which is threatening to the members health, if not provided before his return to the International Medical Center area. However, routine or elective care is not covered when a member is away from the treatment area. A person could join the Gold Plus Plan and then disenroll for the period that he's away from the area, and at some future date, reenroll; however, this involves two complications. One, is the necessity to time the enrolling and disenrolling request so that they conform to his schedule, and even more important is the fact that he must continue to carry supplementary health insurance unless he wishes to risk incurring considerable medical bills while disenrolled.

Another instance where it would be unwise to join an HMO is when a person has a particular medical problem, and has been

treated by a doctor for a long period of time, and whose services he feels he cannot do without.

In the past 6 months, the Palm Beach County enrollment has grown to over 20,000 patients. As is true with any new program, there are some problems. The system isn't perfect. During the first few months, membership assistance, enrollment, et cetera, were handled by the IMC Miami Office. Now, IMC has a regional office in Palm Beach County which takes care of assisting Palm Beach County enrollees. This has enabled International Medical Centers to provide more efficient and effective service to its members. The Citizen Advisory Board is currently working with the regional director to evaluate the Quality Assurance Program in Palm Beach County. It is also assisting in the development of a pamphlet which will provide specific information on the services covered by the Gold Coast Plan. Included will be a complete description of the procedures to be followed for filing a grievance. In time, the Advisory Board will have greater input and will be able to interact with both patients and affiliated providers.

International Medical Centers believe that a well-informed consumer is the best guarantee for receiving proper medical care. The Advisory Board, The International Medical Center Journal, newsletters, are all means of improved communications. As of July 6, International Medical Centers has scheduled a series of 16 seminars for senior citizens to help them live healthier and longer lives. These seminars will include: free lunch or door prizes. That should be some enticement, anyway.

For an HMO to succeed, it is the best interest of the HMO to emphasize preventive health care. Let me explain why this is so. An HMO receives a prepaid capitation fee for each of its enrollees. Therefore, if a patient is kept healthy, the HMO will incur less costs, and at IMC, patients are encouraged to have checkups. The incentive is to treat patients to minimize or prevent serious or chronic illness whenever possible.

The HMO Demonstration Program provides a significant savings to medicare. It does so in two ways: First, it pays private organizations such as International Medical Centers a capitation fee, representing 95 percent of average costs spent by medicare in the areas covered. Five percent may not seem like a great savings, but multiplied by 85,000 plus medicare patients for International Medical Centers alone, it can translate into millions of dollars. If we project the expansion of the Medicare/HMO Programs across the Nation to include 20 to 30 million enrollees, a sufficient impact can be predicted which would solve medicare's financial problems. Second, in the long run, it should save an additional 5 percent in administrative costs because it will eliminate a great deal of paperwork for the Health Care Finance Administration.

The success of the HMO Demonstration Program will require continued cooperation of all Government agencies involved. It will also need effective input from the providers, and just as important, the cooperation and understanding of its members. I have no doubt that this program will succeed.

In conclusion, let me say, that I believe all people in this country, young and old alike, have the right to receive adequate health care at a price they can afford.

Such care cannot be considered a privilege for only those who can afford the ever-escalating costs in the medical sector and the insurance industry. I repeat, it is our right to have adequate health care. In my opinion, it is the responsibility of our elected officials to develop a program which will provide all Americans with adequate health care. I believe the current Demonstration HMO Program is a significant step in this direction. It should be expanded to include all medicare recipients, and should also be developed so it can include people of all ages who wish to participate in it. Thank you.

Mr. MICA. Let me just say I appreciate the conciseness of the testimony, but at about the 5-minute mark, we'll give you a little signal to start wrapping up, because about 5 minutes each would give us the time we had planned.

Mr. Levine?

Every statement will be included in its entirety in the record.

Mr. Murray Levine will proceed, and he has given the committee quite a lengthy transcript——

Mr. LEVINE. Well, I'm not going to use that.

Mr. MICA. He will make comments, and again, about 5 minutes.

Mr. RINALDO. Mr. Chairman, in order to aid Mr. Levine, I request unanimous consent that his entire statement be placed in the record in full.

Mr. MICA. Without objection.

STATEMENT OF MURRAY LEVINE

Mr. LEVINE. My name is Murray Levine.

Let me begin by saying the concept of HMO is excellent, but not for everyone, and it sure needs proper controls overlooked, not by the owners of HMO, but by the officials of public, plus a representative of the people.

Gentlemen, I want to take this opportunity to express my sincere thanks and gratitude to the Honorable Daniel A. Mica, Congressman Rinaldo, and Congressman Smith, and his elected Committee on Aging to hear my complaints about the International Medical Centers, HMO.

It is difficult to tell you in a few minutes the aggravation and torture and pain I have experienced in the past 7 months, merely to get disenrolled for my wife and myself, both being cardiac patients, and I wear a pacemaker.

Remember, gentlemen, you're not dealing with people in the 29-year age bracket, but in the seventies. Is it necessary to expose this group to the biggest killer of their lives in the few years remaining with aggravation.

Therefore, I beg the Congressmen for an extra 2 or 3 minutes to make my presentation.

In December of 1983, we received letters stating that the senior plan that we belong to is being absorbed by the International Medical Centers and HMO plan.

Sometime in December we signed up with dozens of other people. On December 16, because my wife and I are both cardiac patients, we thought it would be best for us if we disenrolled and went to the cardiologist specialist, so we called up the IMC in Miami and

spoke to a person by the name of Alverez, stated,"We signed up on December 6, or thereabouts and had a change of mind, we wish to disenroll." The person took all the information and said, "No problem."

On January 20, spoke to Mr. Vargas at IMC to check if we were disenrolled. He said, "No." The computer still had us on, and he transferred me to a Miss Karen Thornburn.

On February 1, called Miss Thornburn, again, and she told me to please go in and get two disenrollment forms, and mail it to her. That I did.

The next time I called her she said that she could not find them, and would I take photocopies of my carbon copy and send them in. That I did.

In March, called again and asked for Miss Thornburn. I was told she wasn't with the company any longer and was transferred back to Mr. Vargas. He apologized again, and asked me to send him something in writing and directed to him. That I did. He said it would take effect April 1, 1984, because he can't find the other copies.

On March 19, I spoke to Mr. Vargas again, and he said, "Don't worry," he's working on it.

On April 2, still no papers. I called Mr. Vargas again, and he said Miss Lucinda would call from the Public Relations Department and ask me why I am resigning. I told her it would fill a book. She laughed and hung up.

On April 6, I called again and spoke to Mr. Vargas. I asked him why hadn't I received my disenrollment papers. He said he had over 3,000 applications for disenrollment to process. I said, "I understand that, but mine goes back to December 1983."

On April 9, because of all the aggravation and constant stalling with the IMC/HMO, my wife complained of having difficulty in breathing, so I rushed her to the cardiologist. When he examined her, he said to take her right next door into the hospital, she's in the midst of having a heart attack. I took her into the emergency in Doctor's Hospital. She was there from April 9 to April 16.

On April 10, the next morning, naturally I couldn't sleep all night, with she in serious condition. I got in the car and I traveled 50 miles down into the main office into the medical center building. I stormed into Mr. Vargas' office and asked him why all the deliberate delays for months. He said he was just in the process of sending the enrollment, and as long as I was there, he would have his secretary type them up, gentlemen, you have copies there, showing the disenrollment effective April 1, 1984, and signed by him. Note: Item 4.

I have six disenrollment papers, all with different effective dates, all different times that they sent them out.

On May 16, I received two other new copies.

I finally got so disgusted, in June I appealed to Congressman's Mica's office. There I got results in 2 to 3 weeks that took me months to get.

I got a—which you have copies there—from the Government office, stating that according to their records I was disenrolled as of May 1.

The records show from the HMO that I'm disenrolled as of April 1, so the right hand don't know what the left hand is doing, and I'm caught in between with thousands of dollars in bills.

All we ever got from them was alibis and stalling. We are neither fish nor fowl. I fear my wife will get another heart attack because of all this aggravation, and who's going to pay for all the bills.

Gentlemen, because of my testimony, I hope that I'm not penalized either by the IMC or the medicare system.

Thanking you for your kind patience in this lengthy statement, I remain, Murray Levine.

I just want to make a brief recommendation. IMC has over 100,000 members, and from what I read in the papers, has on deposit with the insurance company, $100,000 in the event they go out of business. So each member will receive $1 should they go out of business. Now, that's what I call generous. Remember, 38 percent of the past health plans in the country went broke. For a business that generates nearly $250 million a year, no wonder everyone wants to get into the business. All they need is $100,000 security.

In Florida, there are now pending 12 HMO applications with the Department of Insurance. Will the senior citizens' medical problems come first, or will profit come first? From my experience, profit.

As Mr. Holloway, executive director of District IX, Health Planning Counsel of five counties said, "Even if 1 percent of this new industry goes haywire, the potential for public damage is tremendous."

The HMO is an excellent concept, but not for everyone. Without proper controls we can have a disaster. Millions upon millions of dollars are spent for advertising free glasses, free dental, free drugs, free hearing aids, free, free, free. No wonder every person runs to sign up.

Now, I asked the question, "If medicare system could not make ends meet by giving away all these freebies, then how come an HMO could, and besides spend millions on salaries, millions on advertisers, millions to the shareholders?" Where is it all coming from? Is it coming from the health and welfare of the subscribers by keeping them out of the hospitals, not because they are well enough not to be in, but a borderline patient may not be sent to the hospital because that is their biggest cost.

HMO are paid 95 percent of what the Federal Government estimates to be the average cost for medicare patients living in a specific area.

I suggest that they pay 90 percent and put 5 percent into a fund for one or two offices in each county managed by paid and volunteer seniors so that people who have problems such as mine, will not have to bang their heads against a brick wall trying to get help. All we get is telephones that are always busy, and when you get through, you are transferred from one department to another. Then you get promises, promises and stalling tactics, so the longer they keep you on their rolls, the more money medicare will pay.

I suggest having a graduated scale of deposit with the Florida Insurance Commission, beginning with the minimum of $100,000 for every 1,000 enrollees with a maximum of $5 million security as the

insurance companies have to post. Make them stop their false advertisements via newspapers, and comments by their representatives at group and condominium meetings stating that it would take 4 to 6 weeks for disenrollment to take effect, and you will note, I have their ad on the next page showing from 4 to 6 weeks.

Thank you, gentlemen.

[Attachments to Mr. Levine's statement follow:]

Questions and Answers

Q Is everyone eligible for Medicare eligible for the Gold Plus Plan? What if I have a pre-existing health problem?

A Everyone with Medicare Parts A and B coverage, or Medicare Part B with the exception of people who have end stage renal disease [illegible] the IMC Gold Plus Plan. (Medicare enrollees with Part B coverage should contact IMC at 1-800-462-2273 for information regarding their benefits.) Otherwise, there are no exclusions for pre-existing conditions of any kind and there are no claim forms to fill out ever. The IMC Gold Plus Plan covers all the benefits described here while providing you with freedom from virtually all medical bills.

Q What happens if I join and later change my mind? Will I lose my Medicare benefits?

A No. A Medicare beneficiary may disenroll from IMC at any time by submitting a signed, dated request on forms provided by IMC. It takes no more than 6 weeks, and usually less, to make a disenrollment effective.

And should you disenroll, you will be automatically reinstated in the regular Medicare program.

Q Will I have my own doctor, and how qualified is he?

A IMC means personalized care. You select as your primary physician one of the specialists in General Practice or Internal Medicine participating in the IMC plan. Your IMC primary physician supervises your health care at one of IMC's fully-equipped medical centers (or in the hospital) and arranges for diagnostic, laboratory, x-ray, or specialist services as required.

Q Can I lose my Gold Plus coverage?

A IMC may disenroll a Medicare beneficiary only for the following reasons: Fraudulent statement by applicant. Member moves out of service area. Loss of Medicare Part B coverage. Member allows someone else to use ID card to obtain services. If you are disenrolled from Gold Plus you will be automatically reinstated in the regular Medicare program.

Q If I go outside IMC for services, will IMC still pay for it?

A IMC will pay for emergency services anywhere or urgently-needed services outside the service area. You should notify IMC within 24 hours of receiving such care.

IMC will furnish you with all services covered through its own facilities and physicians. IMC will also pay for emergency services anywhere or urgently-needed care outside the service area. Non-emergency or non-urgently-needed care received outside IMC is not payable by either IMC or Medicare.

Q What are emergency/urgently needed services?

A Emergency services are for an accident or illness of a serious nature that threatens your life or would seriously impair your health if treatment were delayed.

Urgently-needed service is care for an accident or illness, which is less serious than an emergency, occurring while you are temporarily away from the area, but which you need before you can get to an IMC facility to prevent a serious deterioration of your health.

Q What if I have an emergency?

A An IMC physician is available to you 24 hours a day, 7 days a week to help you obtain medical care at any time. The 24 hour emergency number is 653-9872.

In an emergency, you may seek care from any hospital or other health care provider and have the provider notify IMC-HMO.

Q What if I require urgently needed Services?

A While you are temporarily outside of our service area, IMC will pay for this care. However, when you are in our service area you must receive urgently needed care from IMC or the cost of the care will not be paid for by either IMC or Medicare.

Q If I have a complaint, will somebody listen?

A If you are not satisfied with any aspect of the plan, inform the Membership Services Representative at your Medical Center. Every attempt will be made to resolve your problem satisfactorily.

Of course, if you are not satisfied with the resolution of the problem, a formal Grievance Procedure is available. A copy of this procedure can be obtained from IMC. You also retain the regular Medicare appeals process.

Cannon House Office Building
Room 131
Washington, D.C. 20515
Administrative Assistant
Richard McBride
Legislative Assistant
James E. Lamble

#3

DANIEL A. MICA
14th District, Florida

Congress of the United States

House of Representatives

Washington, D.C. 20515

Foreign Affairs
Veterans' Affairs
Select Committee on Aging

June 13, 1984

Mr. Murray M. Levine
6100 Lakemont Circle
Lake Worth, Florida 33463

Dear Mr. Levine:

Thank you for your recent contact with my office expressing your concerns regarding your wife's disenrollment from International Medical Center. I can certainly understand your concern in this matter and want to assure you that I will be as helpful as possible in looking into this.

In an effort to be of all possible assistance, today I have contacted the Medicare Administration and the Health Care Financing Administration. I have requested that officials there promptly look into this matter and respond to me at the earliest possible date. I am sincerely hopeful that my efforts will be beneficial in alleviating your concerns.

I want you to know that I will immediately share with you any information I receive. If you need my assistance in the meantime, please feel free to call on me.

Kind regards.

Sincerely yours,

DANIEL A. MICA, M.C.

DM:ic

PLEASE REPLY
☐ Cannon House Office Building
Room 131
Washington, D.C. 20515

☐ 639 East Ocean Avenue
Suite 303
Boynton Beach, Florida 33435

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

Cannon House Office Building
Room 131
Washington, D.C. 20515
Administrative Assistant
Richard Skinner
Legislative Assistant
James E. Lamble

DANIEL A. MICA
14th District, Florida

Foreign Affairs
Veterans' Affairs
Select Committee on Aging

Congress of the United States
House of Representatives
Washington, D.C. 20515

July 6, 1984

Mr. Murray M. Levine
6100 Lakemont Circle
Lake Worth, Florida 33463

Dear Mr. Levine:

In response to my recent inquiries on your behalf, I have received a reply from the Medicare Administration, and I am forwarding it to you for your information and records.

I was pleased to make this contact for you, and will again be in touch as soon as any other replies are received.

In the meantime, if I can be of further assistance please let me know.

Kindest regards.

Sincerely yours,

DANIEL A. MICA, M.C.

DM:ic
Enclosure

PLEASE REPLY
☐ Cannon House Office Building
Room 131
Washington, D.C. 20515

☐ 999 East Ocean Avenue
Suite 303
Boynton Beach, Florida 33435

THIS STATIONERY PRINTED ON RECYCLED PAPER WITH SOYBEAN INKS

MEDICARE PART B

POST OFFICE BOX 2525, JACKSONVILLE, FLORIDA 32231
Administered by BLUE CROSS and BLUE SHIELD OF FLORIDA, INC

June 27, 1984

The Honorable Daniel A. Mica
639 E. Ocean Avenue
Suite 303
Boynton Beach, Florida 33435

Re: Levine, Evelyn
HICN: 107-18-6127B
DOCUMENT NO: 137149-ic

Dear Congressman Mica:

This is in response to your inquiry of June 13, 1984.

Services rendered to Ms. Levine in May, 1984 have processed and paid. However, according to the query response received from Baltimore on June 26, 1984, services rendered in April, 1984 have denied correctly for HMO involvement.

In order to correct this, please contact the local Social Security office and the HMO involved.

We are sorry for the inconvenience which resulted from this matter.

Sincerely,

Thelma McCurdy, Supervisor
Medicare B Inquiries

Donna L. Fentress

by: Donna Fentress
Service Representative

TM:DF:kt

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to: NAME Murray Levine
SSN 107-18-6122

ROOM 110
200 E. BROWARD BOULEVARD
FORT LAUDERDALE, FLORIDA 33301
DATE 8/5/84

Mr. & Mrs. Levine
6160 Lakemont Cir.
Greenacres City Fl 33463

DEAR Mr. Levine

REFERENCE OUR TELEPHONE CONVERSATION OF _____, THE FOLLOWING RESPONSE IS MADE TO THE QUESTIONS YOU ASKED.

our records indicate you are not still on Home. Please resubmit your bills to medicare.

VERY TRULY YOURS,

M. Eddings, AA

RADIOLOGY
NUCLEAR MEDICINE
ULTRASOUND

BANE AND ASSOCIATES, M.D., P.A.
P.O. Box 10675
Riviera Beach, Florida 33404

Miss Claudia
1-800-342-7586
Medicare
May 16

BILLING OFFICE
(305) 842-0564

DOCTORS HOSPITAL

SERVICES RENDERED AT:
THIS STATEMENT IS FOR PHYSICIAN'S SERVICES ONLY - A SEPARATE CHARGE IS MADE BY THE HOSPITAL FOR USE OF ITS FACILITIES

LEVINE EVELYN E
6100 LAKEMONT CIR
GREENACRES FL 33463

94631

ADM DISCH DATES
4/ 9/84
4/16/84
1ST
BILLING

PATIENT	
LEVINE EVELYN E	90
DATE OF BIRTH 11/28/12	SEX F
965-0210 TELEPHONE	DEAN SILVER, M.D. REFERRING PHYSICIAN

AMOUNT REMITTED $ _____

PLEASE DETACH TOP PORTION AND RETURN WITH YOUR REMITTANCE TO INSURE CREDIT TO YOUR ACCOUNT

DETACH

BANE AND ASSOCIATES, M.D., P.A.
P.O. Box 10675
Riviera Beach, Florida 33404

RE LEVINE EVELYN E

Date	CL	Code	Description of Service	Charges	Payments	Adjustments	Balance
4/10/84	IH	71010	CHEST-SINGLE VIEW	18.(X)			18.(X)
4/12/84	IH	71020	CHEST - PA & LAT	21.(X)			39.(X)
4/12/84	IH	76140	OUTSIDE READING	48.(X)			87.(X)

Pd Check June 19-84

THE DOCTOR DOES NOT ACCEPT MEDICARE ASSIGNMENT
FOR YOUR CONVENIENCE YOUR CLAIM HAS BEEN SUBMITTED
FOR REIMBURSEMENT TO YOU.
PLEASE REMIT BILL IN FULL.
THANK YOU.

TAX I.D. # 59-1227846

KEEP THIS PORTION FOR INCOME TAX PURPOSES

PLEASE PAY THIS AMOUNT ➔ 87.(X)

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

DON B. BANE, M.D.

MAKE CHECK PAYABLE TO
BANE
AND ASSOCIATES, M.D., P.A.

MAIL TO
P.O. Box 10675
Riviera Beach, FL 33404

YOUR CANCELED CHECK IS YOUR RECEIPT

19

24

THIS IS NOT A BILL

330165160

EVELYN LEVINE
8100 LAKE MONT CR
LAKE WORTH FL
33463-1603

06 25 84

EXPLANATION OF MEDICARE PART B BENEFITS

PROCESSED UNDER SPEED CLAIMS PROCESSING

THIS IS A STATEMENT OF ACTIONS TAKEN ON YOUR MEDICARE CLAIM

SERVICES WERE PROVIDED BY NUMBER/NAME	CONTROL NO	PROCEDURE CODE	M	P	SERVICE DATES FROM	SERVICE DATES TO	CHARGES AMOUNT BILLED	CHARGES AMOUNT APPROVED	DEDUC THIS	NET PAY	REMARKS/Explanation
90587 BANE	0180170ZZ252	7101Q250003X			05 01 84	05 01 84	1000	00	00		
	YOUR CLAIM HAS BEEN TRANSFERRED TO HEALTH MAINTENANCE ORGANIZATION H9										
90587 BANE	7813Q250003X				4 09 84	4 09 84	4000	00	00		
	YOUR CLAIM HAS BEEN TRANSFERRED TO HEALTH MAINTENANCE ORGANIZATION H9										
90587 BANE	7102Q250003X				4 09 84	4 09 84	2100	00	00		
	YOUR CLAIM HAS BEEN TRANSFERRED TO HEALTH MAINTENANCE ORGANIZATION H9										
	TOTAL FOR THE ABOVE CLAIM						8100	00	00	00	

THIS IS AN ADJUSTMENT TO CLAIM 0306115L4550 AND IS THE RESULT OF YOUR REQUEST FOR A REVIEW.
YOUR CLAIM HAS BEEN TRANSFERRED TO HEALTH MAINTENANCE ORGANIZATION H9050

107196127B	LEVINE	EVELYN	8100 00 ◀ CLAIM TOTALS

DATE	CLAIM NUMBER	STATEMENT NO	SERVICE TYPE
06 25 84	01	330165160	

Inpatient radiology and pathology physician services and certain ambulance paid at 100% of approved amount ▶	00	00
Amount payable at 80%, subject to the annual deductible ▶	00	
Amount applied toward annual deductible ▶		
Balance payable at 80% ▶	00	00
TOTAL MEDICARE PAYMENT ◆		00

YOU HAVE NOW MET $ OF THE ANNUAL $ DEDUCTIBLE FOR

Blue Cross
Blue Shield
of Florida, Inc

Medicare Part B P.O. Box 2360
Jacksonville, Florida 32231
Duval County 355-3680
Toll Free 1-800-342-7586

International
Medical Centers
HMO
A Federally Qualified
Health Maintenance Organization
Administrative Offices: P.O. Box 69-3830, Miami, FL 33169-0830

#4

Mailed June 16 - 1983

MEDICAL CENTERS
Tel. (305) 643-3000

Miami 1
101 S.W. 27th Avenue
Miami, Florida 33135

Miami 2
140 S.W. 22nd Avenue
Miami, Florida 33135

North Miami
1845 N.W. 2nd Avenue
Miami, Florida 33169

Hialeah
7600 Palm Avenue
Hialeah, Florida 33012

Miami Beach
1801 Lincoln Road Mall
Miami Beach, Florida 33140

Westchester
9705 S.W. 40th St.
Miami, Florida 33165

Edison - Little River
170 N.W. 54th Street
Miami, Florida 33150

Hollywood
7020 Hollywood Blvd.
Hollywood, Florida 33024

GOLD PLUS PLAN DISENROLLMENT FORM

NAME: EVELYN F LEVINE TELEPHONE NO.: 305-165-0210

ADDRESS: 6111 COLLINS AVE MEDICARE NO.: 107-18-6127 B

GREENBRIAR-LAKE WORTH FL. 33463 MEMBER NO.: 113915 01

I WISH TO DISENROLL FROM:

☒ THE GOLD PLUS PLAN

REASON: Dic not want it but my family physician is with us with for years

I HAVE BEEN ADVISED AND UNDERSTAND THAT ALL MY MEDICAL SERVICES, EXCEPT IN CASE OF EMERGENCY, OR OUT OF AREA URGENTLY NEEDED CARE, MUST BE PROVIDED OR ARRANGED BY IMC--HMO UNTIL MY DISENROLLMENT BECOMES EFFECTIVE.

I DO HEREBY CERTIFY THAT I AM VOLUNTARILY DISENROLLING FROM THE GOLD PLUS PLAN OF MY OWN FREE WILL, AND HAVE NOT BEEN REQUESTED TO DO SO BY IMC OR ANY OF ITS AGENTS.

MEMBER'S SIGNATURE

AS SOON AS POSSIBLE
DATE REQUESTED

For I.M.C. use only

RECEIVED BY: _____ DATE: _____
Enrollment Supervisor

Revised 11/8/83

International
Medical Centers
HMO
A Federally Qualified
Health Maintenance Organization

Administrative Offices
P.O. Box 69-3320, Miami, FL 33169-0320
Telephone 621-4222

MEDICAL CENTERS
Tel. (305) 643-3000

Miami
101 S. W. 27th Avenue
Miami, Florida 33135

North Miami
13475 N.W. 2nd Avenue
Miami, Florida 33168

Hialeah
7900 Palm Avenue
Hialeah, Florida 33012

Miami Beach
1001 Lincoln Road Mall
Miami Beach, Florida 33140

Westchester
8160 S.W. 40th Street
Miami, Florida 33155

Edison - Little River
170 N.W. 54th Street
Miami, Florida 33150

Hollywood
2609 Hollywood Blvd.
Hollywood, Florida 33020

Date: April 10, 1984

Dear Mr./Ms. Evelyn Esther Levine

Medicare No. 107-18-6127-B

We have received, verified and confirmed your request for disenrollment from the Gold Plus Plan offered by IMC-HMO to Medicare beneficiaries, a decision that we regret. Your request for disenrollment has been processed, and we have asked Medicare to make it effective the first day of April.

Please understand that up until that date, you will be a member of IMC-HMO and therefore, all your medical services, except in case of a life threatening emergency, must be provided or arranged by IMC-HMO until your disenrollment becomes effective. IF YOU ARE FURNISHED MEDICAL CARE OUTSIDE IMC-HMO, EXCEPT IN LIFE-THREATENING EMERGENCIES, BEFORE April 1, 1984, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

If your Medicare card has a red and gold IMC-HMO sticker on it, you should go to your local Social Security District Office and request a replacement Medicare card which will not have an IMC sticker. When you get your new card, destroy the old one.

In case you are delayed in securing a replacement Medicare card, please affix the enclosed sticker so that it covers the IMC sticker on your current Medicare card. Please do this on the date your disenrollment becomes effective. That date will be April 1, 1984.

If you have any questions about this, please call the Membership Services Department at 643-3000.

Sincerely,

INTERNATIONAL MEDICAL CENTERS, HMO

MEDICARE
BENEFICIARY

International
Medical Centers
HMO
A Federally Qualified
Health Maintenance Organization

Administrative Offices
P.O. Box 69-3520, Miami, Fl 33169-4682
Telephone 621-4222

MEDICAL CENTERS
Tel. (305) 663-3000

Miami
NW 1 W 27th Avenue
Miami, Florida 33125

North Miami
13475 N.W. 2nd Avenue
Miami, Florida 33168

Hialeah
2980 Palm Avenue
Hialeah, Florida 33012

Miami Beach
1691 Lincoln Road Mall
Miami Beach, Florida 33140

Westchester
9350 S.W. 40th Street
Miami, Florida 33165

Edison - Little River
170 N.W. 54th Street
Miami, Florida 33150

Hollywood
2520 Hollywood Blvd.
Hollywood, Florida 33020

Date: April 10, 1984

Dear Mr./Ms. Murray Levine

Medicare No. 107-18-6127-A

We have received, verified and confirmed your request for disenrollment from the Gold Plus Plan offered by IMC-HMO to Medicare beneficiaries, a decision that we regret. Your request for disenrollment has been processed, and we have asked Medicare to make it effective the first day of April.

Please understand that up until that date, you will be a member of IMC-HMO and therefore, all your medical services, except in case of a life threatening emergency, must be provided or arranged by IMC-HMO until your disenrollment becomes effective. IF YOU ARE FURNISHED MEDICAL CARE OUTSIDE IMC-HMO, EXCEPT IN LIFE-THREATENING EMERGENCIES, BEFORE April 1, 1984, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

If your Medicare card has a red and gold IMC-HMO sticker on it, you should go to your local Social Security District Office and request a replacement Medicare card which will not have an IMC sticker. When you get your new card, destroy the old one.

In case you are delayed in securing a replacement Medicare card, please affix the enclosed sticker so that it covers the IMC sticker on your current Medicare card. Please do this on the date your disenrollment becomes effective. That date will be April 1, 1984.

If you have any questions about this, please call the Membership Services Department at 643-3000.

Sincerely,

INTERNATIONAL MEDICAL CENTERS, HMO

MEDICARE
BENEFICIARY

International Medical Centers HMO
A Federally Qualified Health Maintenance Organization

Administrative Offices
P.O. Box 69-3620, Miami, FL 33169-0620
Telephone 621-4222

MEDICARE BENEFICIARY

MEDICAL CENTERS
Tel. (305) 940-3000

West
141 S.W. 27th Avenue
Miami, Florida 33135

North West
19475 N.W. 2nd Avenue
Miami, Florida 33169

Hialeah
2980 Palm Avenue
Hialeah, Florida 33012

West Dade
1601 Lincoln Road Mall
Miami Beach, Florida 33139

Westchester
9450 S.W. 40th Street
Miami, Florida 33165

Kendall - Little River
170 N.W. 54th Street
Miami, Florida 33150

Hollywood
2000 Hollywood Blvd.
Hollywood, Florida 33020

Date: May 5, 1984

Dear Mr./Ms. LEVINE EVELYN. E
6100 LAKEMONT CIRCLE
LAKE WORTH. FL 33463

Medicare No. 10C- 90 SSNO- 107184187B

We have received, verified and confirmed your request for disenrollment from the Gold Plus Plan offered by IMC-HMO to Medicare beneficiaries, a decision that we regret. Your request for disenrollment has been processed, and we have asked Medicare to make it effective the first day of May.

Please understand that up until that date, you will be a member of IMC-HMO and therefore, all your medical services, except in case of a life threatening emergency, must be provided or arranged by IMC-HMO until your disenrollment becomes effective. IF YOU ARE FURNISHED MEDICAL CARE OUTSIDE IMC-HMO, EXCEPT IN LIFE-THREATENING EMERGENCIES, BEFORE May 1, 1984, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

If your Medicare card has a red and gold IMC-HMO sticker on it, you should go to your local Social Security District Office and request a replacement Medicare card which will not have an IMC sticker. When you get your new card, destroy the old one.

In case you are delayed in securing a replacement Medicare card, please affix the enclosed sticker so that it covers the IMC sticker on your current Medicare card. Please do this on the date your disenrollment becomes effective. That date will be May 1, 1984.

If you have any questions about this, please call the Membership Services Department at 641-3000.

Sincerely,

INTERNATIONAL MEDICAL CENTERS, HMO

International Medical Centers HMO
A Federally Qualified Health Maintenance Organization

Administrative Offices
P.O. Box [illegible], Miami, FL [illegible]
Telephone [illegible]

MEDICARE BENEFICIARY

MEDICAL CENTERS
Tel. (305) 643-3000

West
1111 W. 27th Avenue
Miami, Florida 33135

North Miami
1845 N.W. 2nd Avenue
Miami, Florida 33125

Hialeah
1200 Palm Avenue
Hialeah, Florida 33012

Miami Beach
1691 Lenox Road (Rear)
Miami Beach, Florida 33139

Westchester
9000 S.W. 40th Street
Miami, Florida 33165

Kendall - Little River
170 S.W. 104th Street
Miami, Florida 33190

Hollywood
2000 Hollywood Blvd.
Hollywood, Florida 33020

Date: May 5, 1984

Dear Mr./Ms. LEVINE MURRAY, M
6100 LAKEMONT CIRCLE
GREEN ACRES
Medicare No. LAKE WORTH, FL 33463
LOC= 90 LSND= 107186127A

We have received, verified and confirmed your request for disenrollment from the Gold Plus Plan offered by IMC-HMO to Medicare beneficiaries, a decision that we regret. Your request for disenrollment has been processed, and we have asked Medicare to make it effective the first day of May.

Please understand that up until that date, you will be a member of IMC-HMO and therefore, all your medical services, except in case of a life threatening emergency, must be provided or arranged by IMC-HMO until your disenrollment becomes effective. IF YOU ARE FURNISHED MEDICAL CARE OUTSIDE IMC-HMO, EXCEPT IN LIFE-THREATENING EMERGENCIES, BEFORE May 1, 1984, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

If your Medicare card has a red and gold IMC-HMO sticker on it, you should go to your local Social Security District Office and request a replacement Medicare card which will not have an IMC sticker. When you get your new card, destroy the old one.

In case you are delayed in securing a replacement Medicare card, please affix the enclosed sticker so that it covers the IMC sticker on your current Medicare card. Please do this on the date your disenrollment becomes effective. That date will be May 1, 1984.

If you have any questions about this, please call the Membership Services Department at 643-3000.

Sincerely,

INTERNATIONAL MEDICAL CENTERS, HMO

International
Medical Centers
HMO A Federally Qualified Health Maintenance Organization

Administrative Offices
P.O. Box 89-3030, Miami, FL 33189-4062
Telephone 621-4232

MEDICAL CENTERS
Tel. (305) 643-3000

Miami
191 S.W. 27th Avenue
Miami, Florida 33135

North Miami
1475 N.W. 2nd Avenue
Miami, Florida 33150

Hialeah
2980 Palm Avenue
Hialeah, Florida 33012

Miami Beach
1691 Lincoln Road Mall
Miami Beach, Florida 33140

Westchester
9000 S.W. 40th Street
Miami, Florida 33165

Edison - Little River
175 N.W. 54th Street
Miami, Florida 33150

Hollywood
3000 Hollywood Blvd.
Hollywood, Florida 33021

Date: May 29, 1984

Dear Mr./Ms. Evelyn E. Levine

Medicare No. 107-18-6127 B

We have received, verified and confirmed your request for disenrollment from the Gold Plus Plan offered by IMC-HMO to Medicare beneficiaries, a decision that we regret. Your request for disenrollment has been processed, and we have asked Medicare to make it effective the first day of April.

Please understand that up until that date, you will be a member of IMC-HMO and therefore, all your medical services, except in case of a life threatening emergency, must be provided or arranged by IMC-HMO until your disenrollment becomes effective. IF YOU ARE FURNISHED MEDICAL CARE OUTSIDE IMC-HMO, EXCEPT IN LIFE-THREATENING EMERGENCIES, BEFORE April 1, 1984, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

If your Medicare card has a red and gold IMC-HMO sticker on it, you should go to your local Social Security District Office and request a replacement Medicare card which will not have an IMC sticker. When you get your new card, destroy the old one.

In case you are delayed in securing a replacement Medicare card, please affix the enclosed sticker so that it covers the IMC sticker on your current Medicare card. Please do this on the date your disenrollment becomes effective. That date will be April 1, 1984.

If you have any questions about this, please call the Membership Services Department at 643-3000.

Sincerely,

INTERNATIONAL MEDICAL CENTERS/HMO

Medical Centers
HMO
A Federally Qualified
Health Maintenance Organization

Administrative Offices
P.O. Box 69-3630, Miami, Fl 33169-406
Telephone 621-4622

MEDICAL CENTERS
Tel. (305) 643-3000

Miami
1 S.W. 27th Avenue
Miami, Florida 33135

North Miami
3 N.E. 3rd Avenue
Miami, Florida 33161

Hialeah
2000 Palm Avenue
Hialeah, Florida 33012

Miami Beach
1 Lincoln Road Mall
Miami, Florida 33140

Homestead
43 S.W. 4th Street
Miami, Florida 33135

Kendall - Little River
75 S.W. 84th Street
Miami, Florida 33156

Hollywood
330 Hollywood Blvd.
Hollywood, Florida 33020

Date: June 4, 1984

Dear Mr./Ms. Murray Levine

Medicare No. 107-18-6127A

We have received, verified and confirmed your request for disenrollment from the Gold Plus Plan offered by IMC-HMO to Medicare beneficiaries, a decision that we regret. Your request for disenrollment has been processed, and we have asked Medicare to make it effective the first day of April.

Please understand that up until that date, you will be a member of IMC-HMO and therefore, all your medical services, except in case of a life threatening emergency, must be provided or arranged by IMC-HMO until your disenrollment becomes effective. IF YOU ARE FURNISHED MEDICAL CARE OUTSIDE IMC-HMO, EXCEPT IN LIFE-THREATENING EMERGENCIES, BEFORE April 1, 1984, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

If your Medicare card has a red and gold IMC-HMO sticker on it, you should go to your local Social Security District Office and request a replacement Medicare card which will not have an IMC sticker. When you get your new card, destroy the old one.

In case you are delayed in securing a replacement Medicare card, please affix the enclosed sticker so that it covers the IMC sticker on your current Medicare card. Please do this on the date your disenrollment becomes effective. That date will be April 1, 1984.

If you have any questions about this, please call the Membership Services Department at 643-3000.

MEDICARE
BENEFICIARY

Sincerely,

INTERNATIONAL MEDICAL CENTERS/HMO

Mr. MICA. Thank you, Mr. Levine.

Before we go to Mori Fremon, Congressman Smith has one comment.

Mr. SMITH. Mr. Levine raised a question I think we should explain it right now.

The IMC/HMO's originally, and all original State HMO's found that under State laws, put in what the State law required. Right now I understand IMC has about $140,000 on deposit with the State.

However, when you're federally qualified to go into a demonstration project, they're required to put up additional money with the Federal Government. IMC, I understand, has $5 million on deposit with the Federal Government.

So, there is a difference between soley a state HMO and the federally qualified HMO, and the participating demonstration project HMO. They do have additional moneys on deposit.

Mr. LEVINE. That's all I'm concerned about.

Mr. SMITH. Well, we're all very concerned about that.

Mr. LEVINE. I mean, if they go bankrupt or something like, the public should have some security.

Mr. SMITH. Well, we've tried to make it.

Mr. MICA. We will withhold questions until we finish the entire hearing. I think that did put it in, at least, perspective. Ms. Fremon?

STATEMENT OF MORI FREMON

Ms. FREMON. Yes, sir.

Congressman, I'm very glad that this meeting was rescheduled from May, which is when I was in the hospital, and I'm still recuperating from major open heart surgery, a quintuple bypass.

So, my subject is my experience with IMC and HMO.

My name is Mori Fremon and I reside in Hollywood in Mr. Smith's bailiwick. I have lived in South Florida over 35 years, since October 1, 1948, to be exact. I was active as a publicist, journalist, editor and columnist, real estate salesman and broker, until five years ago, April 24, 1979, when I had a heart attack.

I joined IMC last year, some time after having moved to Hollywood from Miami Beach. First, to discontinue traveling every 3 months to my doctor in Miami Beach; second, because the IMC/HMO advertising was so effective, especially with Glenn Ford as most convincing spokesman. The wide range of benefits of the gold plus plan offered attractive advantages.

An appointment was arranged with the cardiologist, Dr. Levy, at the Hallandale Medical Center, 1117 Hallandale Beach Boulevard, where an interview and thorough examination took place. We requested my records from St. Francis Hospital in Miami Beach, which supplied my most recent major medical history. The dermatologist at the center took care of some minor skin problems and prescribed medication.

In case it appears that I'm trying to impress this committee with the premise that all was sugar and spice for me at IMC, that is not

the case. On the contrary. An appointment with a dentist, may I name him——

Mr. MICA. I prefer not.

Ms. FREMON [continuing]. Was arranged. The following letter to Dr. Recarey, Jr., president of IMC/HMO is self-explanatory, and I would like to read it since it tells of the entire incident.

But, first, I want to report that Mr. Gerry Atchison gave his personal attention to my problem, which resulted in a satisfactory solution.

My letter to Mr. Recarey was dated November 22, 1983:

Dear Mr. Recarey: To quote from your "Letter from the Chairman" in your first edition of the IMC Journal, "and if you see some improvements that could be made at IMC, tell us." So I'm telling you.

I became a member of your HMO August 1, and I consider it a marvelous organization. I have been very satisfied with the services I have received, and have been recommending the HMO to my family and friends. However, I'm obliged to come to a specific issue for the welfare of the organization.

My experience with the assigned dentist has been a near disaster. I would prefer to avoid a malpractice suit, which would be detrimental to the organization, which is not my intention. I'm, therefore, presenting the matter to you for remedial action.

I went to the assigned dentist November 7. The first visit resulted in a cleaning and x ray. The second visit, November 14, was devoted to a simple filling. It seemed strange to me that the dentist injected my cheek instead of the gum area of the tooth to be filled. It seemed strange, because in all the 34 years with one dentist on Miami Beach, all fillings were done with the injections in the gum area.

The tooth drilling by the dentist was still painful, despite the supposed numbing effects of the injection. Then for the next few days, there was extreme pain, and my left cheek swelled up looking as if there were a round object lodged in my mouth. Even after some of the pain subsided, the pain and the swelling was still there, even until today, which is November 22, although somewhat diminished. It is very difficult for me to open my mouth wide enough for the intake of food.

Quite naturally, I telephoned the dental office last Wednesday and was told that this was the doctor's day off. On Thursday, I spoke with one of his employees, who said he could not help me and that the doctor was with a patient. When my patience gave out, I used rather firm language and the doctor finally came to the phone on Friday. He at first firmly stated he had not injected my cheek. When I very strongly brought to his attention, that although I had no expertise in dentistry, I had full control of my mental alertness, and was not a senile individual, despite his treatment of me as such. He then said, well I must have bitten my cheek, which is unadulterated nonsense. He asked me to come to the office and he would take a look, but would not advise me as to how to bring down the swelling, nor what medications he had used for the injection.

Well, anyway, going to his office was a long way and time consuming. In any case, Mr. Recarey, I would never return to this doctor, having absolutely no confidence in him. Judging from your eloquent "Letter from the Chairman," I am sure you will want to take immediate and effective action in this matter. Thank you.

Now, as I said, Gerry Atchinson made another dentist available, and I don't have to mention him, even though he was great.

Mr. MICA. Let me just clarify this for all of the witnesses and for anyone who's going to make a statement later.

The committee does not have any preference whether or not you would mention the specific doctor's name. At this hearing, however, I would recommend that you not, and simply for this reason: If you pick out a specific individual and you make an allegation or a charge in public, you, the witness, could have some responsibility for that statement.

Ms. FREMON. As a matter of fact, it occurred to me, Mr. Mica.

Mr. MICA. So, we want to hear the problems and concerns, but unless you talk to your lawyer and know exactly what you're about to say, I'd be very cautious about it.

Thank you.

Ms. FREMON. Anyhow, since this is good, it's OK to mention this doctor, isn't it?

Mr. MICA. I think so, is there a lawyer here?

Ms. FREMON. Another dentist, Dr. George J. Vouis was available to me. His prognosis, written December 19, 1983, "left side had mandibular infection which caused pain and swelling, which was excrutiating, and has persisted to now. Recommended moist heat and pain pills. Signed; George J. Vouis, D.D.S."

That finishes the dental; it's taken care of.

A few days ago, I called the Hallandale Medical Center and asked whether I would have to go back to the dentist who had done so much damage. I was informed that he was no longer servicing the organization. Dr. Vouis had replaced him, which pleased me. His office and personnel are exemplary.

Another matter: An appointment with the optometrist, Dr. Howard Braverman, well, it's OK, it's good.

I'm sorry. OK, his examination brought to light my damaged right eye, due to a broken blood vessel. His brother, the ophthalmologist, gave me indepth examinations and tests, and then determined there was nothing he could do to alleviate the situation.

I planned to arrange for an appointment at Hadassah Hospital's world famous ophthalmology department in Israel, when I would visit my daughter and five grandsons in Jerusalem in July.

Then, coronary complications developed; a stress test at Miami General Hospital resulted in hospitalization at Mount Sinai Medical Center, with which IMC has an affiliation.

Very brief. I entered May 7, received a catheterization May 8 to determine what procedures were to be followed.

Later I was told that 20 cardiologists, Dr. Philip Samet's team, met that afternoon and studied the slow motion pictures of my catheterization test. They unanimously agreed that a quintuple bypass operation was necessary.

May 10, I was brought down to the surgery department to be prepared for the operation the following day. The team of surgeons headed by Dr. Jack J. Greenberg, among them Dr. William Yahr then took over. Several weeks later, I was informed that I had had 98 percent blockage.

I cannot possibly find enough words for praise and gratitude I owe to the staff at Mount Sinai Medical Center, the cardiologists, surgeons, nurses, aides of all kinds, clerical, et cetera without sounding saccharine. I'm here, living proof, very much alive and well, and I readily say that the staff of IMC, including those at Miami General Hospital, were initially responsible for saving my life by their diligent and caring attention to my problems as they arose.

There are many names to mention, Alice Cirillo, the manager of the office.

OK, OK no more, Gerry Atchinson, who helped me solve a lot of problems.

Mr. MICA. Thank you, if we can move on to Mr. Custage.

Ms. FREMON. Please, as to the last paragraph.

Another arrangement with Dr. Robert Segall was arranged, but I had to be here today, and so it will be rescheduled.

Mr. MICA. OK, thank you.
We'll put the entire statement in the record.
[The prepared statement of Mori Fremon follows:]

Notes: For the appearance before a congressional committee.
Subject: My experience with IMC-HMO.
Date: July 9, 1984.

My name is Mori Fremon. I reside at 2401 South Ocean Drive, Hollywood, Florida. My phone number is (305) 925-7531. I have lived in South Florida over 35 years (October 1, 1948). I was active as a publicist, journalist, editor and columnist, real estate salesman and broker, until five years ago (April 24, 1979), when I had a heart attack.

I joined IMC last year, some time after having moved to Hollywood from Miami Beach. First, to discontinue traveling every three months to my doctor in Miami Beach; second, because the IMC-HMO advertising was so effective, especially with Glenn Ford as most convincing spokesman. The wide range of benefits of the Gold Plus Plan offered attractive advantages.

An appointment was arranged with the cardiologits (Dr. Levy) at the Hallandale Medical Center (1117 Hallandale Beach Blvd.), where an interview and thorough examination took place. We requested my records from, St. Francis Hospital, which supplied my most recent major medical history. The dermatologist took care of some minor skin problems and prescribed medication.

In case is appears that I'm trying to impress this Committee with the premise that all was sugar and spice for me at IMC, that is not the case. On the contrary. An appointment with a dentist was arranged. The following letter to Mr. Miguel Recarey, Jr., President of IMC-HMO is self-explanatory and I would like to read it, since it tells of the entire incident. (Read the letter.)

But first, Mr. Gerry Atchison's personal attention to my problem resulted in a solution. He arranged for an appointment with another dentist. I would also like to read Mr. Recarey's reply. (Copies of both letters are made available to this Committee.)

Another dentist, Dr. George J. Vouis, was available to me. His prognosis, written December 19, 1983, "left side had mandibular infection which caused pain and swelling, which was excrutiating, and has persisted to now. Recommended moist heat and pain pills. Signed: George J. Vouis, D.D.S."

A few days ago I called the Hallandale Medical Center and asked whether I would have to go back to the dentist who had done so much damage, I was informed that he was no longer servicing the organization. Dr. Vouis had replaced him, which pleased me. His office and personnel are exemplary.

An appointment with the optometrist, Dr. Howard Braverman, was arranged. His examination brought to light my damaged right eye, due to a broken blood vessels. His brother, Stanley, the Ophthalmologist, gave me in-depth examinations and tests, and then determined there was nothing he could do to alleviate the situation. (He is no longer servicing IMC patients.)

I planned to arrange for an appointment at Hadassah Hospital's world-famous Ophthalmology Department in Israel, when I would visit my daughter and five grandsons in Jerusalem in July.

Then complications (coronary) developed; a stress test at Miami General Hospital resulted in hospitalization at Mount Sinai Medical Center, with which IMC has affiliation.

I entered May 7, received a catheterization May 8, to determine what procedures were to be followed.

Later I was told that twenty cardiologists (Dr. Philip Samet's team) met that afternoon and studied the slow motion pictures of my cathetericatión test. They unanimously agreed that a quintuplet by-pass operation was necessary. May 10, I was brought down to the surgery department to be prepared for the operation the following day. The team of surgeons headed by Dr. Jack J. Greenberg, among them Dr. Wm. Yahr then took over. (Several weeks later I was informed that I had had 98% blockage.)

I cannot possibly find enough words for praise and gratitude I owe to the staff at Mount Sinai Medical Center, the cardiologists, surgeons, nurses, aides of all kinds, clerical, service personnel, without sounding saccharine. I'm here, living proof, very much alive and well, and I readily say that the staff of IMC (including those at Miami General Hospital) were initially responsible for saving my life by their diligent and caring attention to my problems as they arose. As for Mount Sinai, I discussed a way in which I could show (in a small way) July 16, I'm scheduled to return to Mt. Sinai for a checkup by the surgical team.

As to the Ophthalmologist who replaced Dr. Braverman, Dr. Robert Segall, as an accomodation to me, IMC had arranged an appointment to obtain a second opinion. However, it was necessary to reschedule the meeting with him in order for me to appear here today.

Thank you.

MORI FREMON, INC.,
Hollywood, FL, November 22, 1983.

Mr. MIGUEL RECAREY, Jr.,
Chairman, International Medical Centers,
75 East 7th Street, Hialiah, FL.

DEAR MR. RECAREY: To quote you from your "Letter from the Chairman", in your first edition of the I.M.C. Journal, "And, if you see some improvements that could be made at I.M.C., tell us." So, I'm telling.

I am a recent member of H.M.O., (August 1st), and I consider it a marvelous organization. I have been very satisfied with the services I have received and have been recommending HMO to my family and friends.

However I am obliged to comment to a specific issue, for the welfare of the organization.

My experience with the assigned dentist, Dr. Lee Casler, has been a near disaster. I would prefer to avoid a mal practice suit, which would be detrimental to the organization, and which is not my intention. I am therefore presenting the matter to you for remedial action.

I went to the assigned dentist, Dr. Lee Casler, at 3395 Sheridan St., Hollywood. The first visit (Nov. 7) resulted in a cleaning and X-Rays. The second, Nov. 14. was devoted to a simple filling.

It seemed strange to me that the dentist injected my cheek instead of the gum area of the tooth to be filled. It seemed strange, because in all the thirty four years with one dentist on Miami Beach all fillings were done with injections in the gum area.

The tooth drilling by Dr. Casler was still painful, despite the supposed numbing effects of the injection. Then, for the next few days there was extreme pain, and my left cheek swelled up, looking as if there were a round object lodged in my mouth. And, even after some of the pain subsided, the pain and the swelling were still there, even until today, (Nov. 22), although somewhat diminished. It is very difficult for me to open my mouth wide enough for the intake of food.

Quite naturally, I telephoned the dental office last Wednesday, and was told that it was Dr. Casler's day off. On Thursday I spoke with one of his employees, who said she could not help me, and that the doctor was with a patient.

When my patience gave out I used rather firm language and the doctor finally came to the phone on Friday. He at first firmly stated that he had not injected my cheek. When I very strongly brought to his attention that although I had no expertise in dentistry, I had full control of my mental alertness, and was not a senile individual, despite his treatment of me as such.

He then said, well, I must have bitten my cheek, which is unadulterated nonsense. He asked me to come to the office and he would take a look, but would not advise me as to how to bring down the swelling, nor what medication he had used for the injection.

Going to his office from where I live is a time consuming trip of approximately four hours, taking two buses, each one scheduled at one-hour intervals.

It seems to me that another dentist could be selected to cover the area in which I live and where the HMO office is located, 1117 Hallandale Beach Boulevard.

In any case, I would never return to Dr. Casler, having absolutely no confidence in him.

Judging from your eloquent "Letter from the Chairman", I am sure you will want to take immediate and effective action in this matter.

Sincerely,

MORI FREMON.

INTERNATIONAL MEDICAL CENTERS HMO,
Boynton Beach, FL, January 4, 1983.

MORI FREMON, INC.,
2401 S. Ocean Drive, No. 2608, Hollywood, FL.

DEAR MS. FREMON: As President of International Medical Centers, it is always a pleasure to hear from people like yourself who take a genuine interest in the wel-

fare of our organization. You are correct in assuming that we are a health maintenance organization with our priorities set on continuous improvement, in order to provide quality health care.

We are indeed in agreement with your concept of the HMO as the health care system of the future. It is this very kind of enthusiastic support which you have demonstrated that contributes to our success.

Please accept my apologies for what may appear to be a rather lengthy delay in response to your letter of November 22, 1983. However, I have been kept current of your situation by our Corporate Development Office and have been awaiting a resolution to your problem. I am pleased to known that we have been of service to you and were able to provide you with the necessary medical care you had requested.

Moreover, my intention is that this unfortunate situation has been completely resolved to your satisfaction. You have my sincerest regrets for any pain and inconvenience which you may have experienced previously. I only hope that our continued demonstration of service and concern for your welfare will restore your faith in our organization and its goals.

Very truly yours,

MIGUEL RECAREY, Jr., *President.*

Mr. MICA. Mr. David Custage, please proceed.

STATEMENT OF DAVID CUSTAGE

Mr. CUSTAGE. Ladies and gentlemen, my thanks to the Congressmen for inviting me to tell my story today.

I don't have a formal written statement. I come to tell you about the terrible time that I spent in 24 hours trying to help an 81-year-old woman who was dying, and had a 93-year-old husband.

They live in a one-room condo, and don't get the idea, grandeur of condo. This condo cost $19,000, and represented their life savings when they bought that condominium.

Now, this is what happened.

I got a call from Mr. Cherry, and I've known him for 50 years, and I was told that his wife, Celia, who is 80 years old, had an inoperable case of cancer and was dying, and in the time that it was discovered to the present date, she had lost over 50 lbs. and she wasn't feeling well.

I asked him what his assets were, et cetera, and what help he was getting. He explained to me that he had joined HMO Gold Plus, and with all the free inducements, the glamour, et cetera, and they were doing the best they could.

He called them, and they found that she was dehydrating, and they immediately put her into Humana Hospital. I went to visit her there, and I found that she had feeding, intravenous feeding and other care that she, obviously needed.

It was obvious to anybody that the woman was dying. I now asked the nurse if I could talk to the doctor. She made a call, but the doctor was not available, but he would call me back. He never called me back.

I asked her what they were doing for her, and they said they were trying to make her last days as comfortable as possible, but we all understand what the situation was.

Unfortunately, there was no life I could save, except that the next day, I got a call at 6 o'clock in the morning from her husband, hysterical on the phone. I asked him what happened?

Oh, the HMO doctor had decided that she now had become custodial, and didn't fit into the plan, and so he discharged her without any regard as to what would happen to her, and what care was available.

At 7 o'clock at night, an ambulance pulled up, dumped her into the room, and this is the scene I saw when I got there at 7 o'clock in the morning.

I walked into the small bedroom and this 80-year-old woman was lying naked on the floor moaning, she had fallen off the bed. The husband, who is 93 and 4 feet tall, was hysterical. He had been up all night; he didn't know what to do next, and he felt the best thing to do was to lay down alongside of her, and they would both go out.

I immediately got on the phone, and I called the hospital, and they explained to me that they have to follow orders. HMO had discharged her, and that's that.

I then started the first of 26 phone calls, and I have documentation, and here's what I heard.

"Well, the HMO is no longer responsible because she is custodial." Well, I had to go to the law books and so on to find out what it meant, but certainly the wonderful brochure of HMO, which tells you all the benefits, no charge, no charge, giving you the whole world, but here in the bottom, in small print, mixed up with a lot of other situations, where you have to be a medical man to know, was that care for custodial service was excluded.

I pleaded with the people at HMO, and I was transferred from person to person, and each one responded to me the fact that there was not their responsibility, and I pleaded, and finally I stood up and I asked for an officer of this HMO. I'm not mentioning names. What I am saying is to point out that there are exceptions. In this particular case, I finally got to this officer, and I pleaded with him to help.

It was a matter of a short-term; I don't know how many days, but for out of decency to a human being would they please arrange to take her back into the hospital.

"No, no, go get yourself a nursing home, et cetera, et cetera," and finally when I became insistent, and told him I would call Congressman Mica, he said, "What are you trying to do, threaten me?"

Now, my business experience for 35 years or more, was in the financial world, and I helped finance businesses, and I had worked with people and I had a pretty good record to show it.

I have documentation for everything that I'm saying.

I then decided that there was no way that I could get any help. The hospital had already told me that what they found was that the laws, the rules, were faulty. The HMO laws and rules were faulty. Medicare was faulty because they led a category of people and all of us one day may be in that category where we need custodial help, and we are not covered by medicare, medicaid, or Government. We are left to be on our own, and if I hadn't gotten involved in this situation, who would talk to this man Mr. Cherry?

They never had a car in their life. They never had any luxuries; they took their life savings to buy this condominium for peace of mind, and when they heard the glamorous story of what the HMO does for you beyond Medicare, gives away free, free, free everything, this man figured well, with his limited resources since he didn't have to pay any dues, he didn't have to pay any fees, all he had to do was sign up.

Well, he did, and what happened? I went through the horror of this until finally my prayers were answered. I remembered that Congressman Dan Mica was on the committee for the aged people, and this was a case that he should know about.

Those aging people who are not able, don't have transportation, spend 2½ hours on a bus to get to a doctor or a hospital, and of all people, I've got to extend at this time, my thanks to a member of this staff, who was truly an angel. Her name is Diane Kohl, and she's sitting right there.

We have never met before, but she responded. She responded in such a way that was incredible. She got on that phone and she got busy.

Mr. MICA. I hate to cut you off while you're praising my staff.

Mr. CUSTAGE. Let me say this. I'm trying to be brief, but this is truly important for this reason: If I can save one person from the horror that I went through, let me tell you the end of this.

I got a call from the director of the Humana Hospital, who told me he had a bed, but the HMO doctor refused to admit the patient back, and he was helpless.

I called my own doctor in Boca Raton Hospital, and he was helpless, and then the time quotient came in, and the Social Service person at Humana Hospital, another angel, and I want to mention her name, Beverly Slattery. She said to me, "Run down to the State Department of Health and Rehabilitation Services Office and file an application to get her out of HMO, and let's see if they can help."

It was very interesting. I went down there. It would take 2 to 3 weeks, possibly 4 weeks to handle the paperwork.

Now, when a person's dying, did I have 4 weeks? I didn't know if I had 4 days, but I was looking for her to have a decent place to be with help.

I called Hospice. They promised to send a nurse. I finally called back, and apparently somebody had reached the HMO Office because now they were answering the phone, but constantly reading to me the rule that they weren't responsible.

I said, "Look, what can you do for me now?" They said, "OK, we will send a nurse." "How soon will she be here?" "Half-hour."

A nurse came like hours later and apologized that they were so short of help that she even gave up her lunch hour to come. She was a wonderful nurse, but she did something that I questioned. She made a prescription for morphine, and I wondered, are nurses qualified to give prescriptions?

Now, but, we accepted it, because anything to take this pain away from this woman, laying there and moaning, dying.

I then got a phone call after many, many phone calls that arrangements had been made——

Mr. MICA. Will you please summarize?

Mr. CUSTAGE. I'm going to summarize.

An ambulance finally came and took her to Humana Hospital, took her back to Humana Hospital.

A VOICE. All right, that's enough.

Mr. MICA. Let me just say again, we're warning each of the witnesses and we're asking them to summarize, but let me just say, with the number of people in this room, we're going to have to ask

that we don't have any outbursts, and I will pledge right at this time, that I'll try to cut each one off at 5 minutes, and give them 1 minute to summarize, but we cannot have that; it will create a difficult problem.

Mr. RINALDO. Mr. Chairman, I think it should be pointed out to everyone here, particularly the witnesses, that anyone who has printed testimony, that testimony is included in the record in full. Every Member of Congress, every member of the full Committee on Aging, gets a copy of that report in which all the testimony is printed, so there really is no reason for any duplicative effort, because it's going into the record. You don't have to say every word.

If we don't stop it at the 5-minute mark, other people down along the line are going to be deprived of their time to speak.

Mr. MICA. With, we'll go on to the next witness.

Mr. CUSTAGE. May I sum up one point, please?

A VOICE. Mr. Mica, this is becoming a marathon with these people. Please, we got a lot of people here.

Mr. CUSTAGE. Thank you for the opportunity.

Mr. MICA. The next witness is from the Florida Insurance Commissioner's Office, the Chief of the Bureau of Allied Lines is Clyde Galloway, Jr. Mr. Galloway, please proceed.

STATEMENT OF CLYDE GALLOWAY, JR.

Mr. GALLOWAY. Thank you, Mr. Congressman.

On behalf of Mr. Gonnar it is a pleasure to be here and we appreciate the efforts that your office and this committee are putting forth.

If I could, I'll be brief, but at this point I'd like to read one quote from the statute that I think surmises the basic intent and the posture that the State of Florida recognizes HMO's.

"Faced with continuation of mounting costs of health care, coupled with the State's interest in high quality care, the Legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services."

It is from this humble basis that the administration of HMO's in Florida began, and briefly, what I will try to do is give you a summary of how regulation is taken care of in Florida.

There are two separate state agencies responsible for the other side of this industry: The Department of Insurance and the Department of Health and Rehabilitative Services.

Jointly, these two agencies participate in the initial review process to determine licensing or capability of any applicant.

They also join forces in the regulation from an independent standpoint so that the areas they're charged with to determine the continued statutory compliance.

However, the separate agencies do monitor different aspects of the industry.

The Department of Health and Rehabilitative Services is responsible for the regulatory controls over the quality of care that is being provided from a medical standpoint.

HRS also reviews the capability of the delivery system to determine the sufficiency of the medical services that are to be provided, and are in fact, being provided once an applicant is licensed.

On the other hand, the Department of Insurance reviews the business aspect of the industry, such as financial status of a prospective applicant, and the continued status once an applicant is licensed, the marketing endeavors, the contractual arrangements and Complaints.

The financial status is certified with the Department of Insurance by company officials on a quarterly basis. This information is reviewed in-house, as well as field examinations being conducted no less than once every three years. Marketing materials used in the manner which misrepresented the services of the organization, or which is determined to be deceptive or misleading, could provide the grounds for administrative release, such as suspension or revocation of the license. Further, the Department of Insurance reviews the contractual arrangements to be entered into by the HMO with members of the public to determine the sufficiency of the rates and the services that are being provided from the standpoint of their compliance with the statutory guidelines, both on the State level and within the guidelines of some of the Federal requirements. Also, the Department of Insurance reviews and participates in claims disputes for a lack of a better determination or designation as an arbitrator. Our major input in this area is to act an intermediary to negotiate between the prospective claimant and the HMO, where disputes have arisen.

This briefly outlines the regulatory scheme that is currently in force in the State of Florida from a State aspect. Since this is a review of the Medicare Program, the pilot program here in the State of Florida, I've been asked to give you a few indications of some of the problems, or problem areas that we've had or experienced. The major problem that we saw initially was a lack of understanding about the concept of HMO's to begin with.

Individuals that desire to participate in a HMO should be made aware of the aspects of a HMO before they join. For example, they should understand that the lack of freedom of choice is going to be incumbent upon their membership.

Individuals must understand that once they join an HMO, they are required to use its medical personnel, except in certain instances, and those are illuminated in a contractual arrangement that they enter into.

Advertisements of this program must be attuned to the clientele that they are to reach. Advertising to medicare beneficiaries must be carefully prepared in an understandable fashion to avoid misconception of the program.

The other major areas that we attain problems is the enrollment and disenrollment process; however, it appears from what we can see in determining this, that as a result of HFCA's effort the procedure has been expedited and is operating at a greater level of proficiency currently.

Recognizing the relative youth of this industry in Florida and the accomplishments thereof are very encouraging at this point.

As a result of the labors of those associated with this industry the citizens of Florida are now participating in a viable alternative health care delivery system today.

Thank you.

[The prepared statement of Clyde Galloway, Jr., follows:]

PREPARED STATEMENT OF CLYDE GALLOWAY, FLORIDA INSURANCE COMMISSION

As a brief history, regulation of Health Maintenance Organizations in the State of Florida commenced after the 1972 Legislative Session. In its enactment the Legislature made the following Declaration of Legislative Intent:

641.18(1) Faced with the continuation of mounting costs of health care, coupled with the State's interest in high quality care, the Legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services.

(2) Health Maintenance Organizations, consisting of pre-paid health care plans, hereinafter referred to as "plans" are developing rapidly in many communities. Through these organizations, structured in various forms, health care services are provided directly to a group of people who make regular premium payments.

(3) These plans, when properly operated, emphasize effective cost and quality controls.

It is apparent from this statement that the enhancement of an alternative health care delivery industry, which provides the proper quality assurances, has received the blessings of the Florida Legislature.

After providing the above Statement of Intent, the Legislature further clarified the manner in which this blossoming industry should be regulated. The regulatory jurisdiction regarding Health Maintenance Organizations was concurrently vested with two state agenceis, the Department of Insurance and the Department of Health and Rehabilitative Services.

Jointly, the agencies participates in the review of prospective applicants to determine initial compliance. Likewise, the agencies join forces in the pursuit of administrative remedies once it is determined that a licensed entity no longer satisfies the statutory mandates. However, individually the respective agencies monitor different aspects of this industry.

The Department of Health and Rehabilitative Services is responsible for the regulatory controls regarding the quality of care provided by the respective Health Maintenance Organizations. Futher in this regard, the Department of Health and Rehabilitative Services reviews the capability of the delivery system to determine the sufficiency of the medical services being provided.

The Department of Insurance reviews the "business" aspects of this industry, such as the financial status of the entities, marketing endeavors, contractual arrangements, and claims disputes. The financial status of an entity is certified to the Department of Insurance by company officials on a quarterly basis. The use of marketing materials in a manner that misrepresents the services of the organizations, or which (could be) is determined to be deceptive or misleading, could provide a grounds for administrative relief. Further, the Department of Insurance reviews the contractual arrangements to determine the statutory compliance of the rates charged and the services provided therein. Also, we participate in the review of the claims disputes us, for the lack of a better designation, arbitrators; this review is geared to determine legitimacy of the particular dispute in question.

This briefly outlines the general regulatory scheme applicable to Health Maintenance Organizations in Florida.

There are certain concerns which apply specifically to those Health Maintenance Organizations participating in the Medicare Demonstration Program, which I will discuss now:

1. Individuals desiring to participate in the program need to become aware of the operational aspects of a Health Maintenance Organization before they join. This embodies informing future participants of the lack of "freedom of choice". Individuals must understand that once they join a Health Maintenance Organization they are required to use the medical personnel thereof, except in certain instances (out of area coverage and emergencies).

2. The advertisement of this program must be attuned to the clientele that is to be reached by this endeavor. Advertising the Medicare beneficiaries must be carefully prepared in a clear and understandable fashion so as to preclude the establishment of misconceptions regarding the benefits of this particular program.

3. The enrollment and disenrollment process has generated concerns in the past. However, it appears that the continued review of these procedures has produced a greater level of proficiency.

4. The quality of care issued is one that is encumbent in any review of this industry, whether it be on the Federal, State on local level.

Recognizing the relative use of this industry in Florida, the level of a accomplishments achieved at this point in time are very encouraging. In fact, as a result of the labors of those associated with this industry, the citizens of Florida are successfully participating in this alternative health care delivery system today.

Mr. MICA. Our next witness is from the U.S. Health Care Financing Administration, Mr. Wayne Fowler, who's the Director of Health Plan Operations.

Mr. Fowler?

Mr. FOWLER. Thank you.

If I may, I would just summarize with submitted written testimony.

Mr. MICA. Without objection. Your entire testimony and as we said before, all testimony will be submitted in its entirety in the record.

STATEMENT OF WAYNE FOWLER

Mr. FOWLER. Thank you.

The Health Care Financing Administration recently published a regulation to implement the new Tax Equity and Fiscal Responsibility Act of 1982, which changes the way HMO's are reimbursed under medicare.

We will reimburse HMO's similarly to the way they're paid under the demonstration projects today. We think this new regulation and new law, the 1982 law, will have significant impact on the delivery of health care within the country.

The experience that we've gained here in the demonstrations will be invaluable in helping us administer that program.

I might give you just a few numbers here. Regarding medicare beneficiaries enrolled in the demonstrations in the Florida area, there are 30,000 enrolled in the Miami area; there are 22,000 enrolled in the Palm Beach area; 24,000 in Broward; and 19,000, in the Tampa-St. Petersburg area, or a total of approximately 95,000 people.

In the Miami area this represents a 10 percent concentration of the medicare eligible population there. With the implementation of the new law that emulates the demonstrations, we expect significant and rapid growth in the number of medicare beneficiaries who join HMO's.

We feel that the demonstrations here in Florida have been successful, and we have learned a great deal about administering HMO provisions from this.

I'll be glad to take any questions that you may have.

[The prepared statement of Mr. Wayne Fowler follows:]

PREPARED STATEMENT OF WAYNE FOWLER, DIRECTOR, GROUP HEALTH PLAN OPERATIONS STAFF, BUREAU OF PROGRAM OPERATIONS, OF THE HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

I am pleased to be here today to discuss with you the efforts of the Health Care Financing Administration (HCFA) to encourage competition in the health care

market place by fostering high quality, cost-effective health care delivery alternatives.

I believe you are aware of our long-standing interest in health maintenance organizations (HMOs) as particularly promising delivery and financing alternatives. Since 1978, HCFA has supported many HMO demonstration projects which have provided incentives for increased enrollment of Medicare beneficiaries and reduced Medicare benefit costs through capitated reimbursement.

We have been particularly anxious to foster sufficient competition so as to detect whether competing alternative health plans can generate general market effects. As recently as two years ago, Hal Luft, an expert in HMOs and professor of health policy at the University of California at San Francisco, was unable to detect market effects in several "competitive" areas he studied. He hypothesized that the competitive environment in any one area had not reached the critical point at which firms had lowered prices to attract clients. Now we feel that point is attainable, at least in some geographic areas, with the participation of the major Federal payors, Medicare and Medicaid. Based in part on the knowledge gained through our demonstration projects, we are now undertaking to implement legislation which should result in greater participation of Medicare beneficiaries in health maintenance organizations. We have recently proposed a regulation to implement the provision of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which establishes new incentives for beneficiaries to enroll in HMOs and Competitive Medical Plans. The regulation provides for Medicare reimbursement at up to 95 percent of the Adjusted Area Per Capita Cost (AAPCC) for a specific geographic area. The AAPCC is adjusted according to variations in the Medicare population by age, sex, welfare status, and institutional status. We pay the HMO a weighted average of the AAPCC based on the HMO's specific enrollment of Medicare beneficiaries. Under the new TEFRA provision, if we calculate that the HMO's costs are lower than 95 percent of the AAPCC, the HMO must either return the difference to beneficiaries in enhanced benefits, or accept the lower payment.

Based on our demonstrations that have served thousands of elderly and disabled Americans, we believe that Medicare beneficiaries will select HMO coverage when they understand its advantages for them. These advantages could include a more comprehensive benefit package and lower out-of-pocket costs.

As a result of TEFRA, we expect a dramatic rise in HMO enrollment for Medicare beneficiaries—up by as many as 600,000 beneficiaries in the next three to four years, with a 50 to 100 percent increase in the number of contracts between HMOs and Medicare.

I would now like to describe to you our overall research program in health care competition, which served as the laboratory for this reimbursement innovation, and then turn to a discussion of our HMO demonstration projects in Florida, which I know are of particular interest to this Committee.

MEDICARE COMPETITION DEMONSTRATIONS

In the Spring of 1982, HCFA issued a Request for Proposal to implement demonstrations to test alternative competitive models for delivering health care to Medicare beneficiaries. Our intent was to encourage competition among insurers and providers of health care by allowing Medicare beneficiaries a choice of alternative health plans (AHPs), including HMOs. AHPs would compete for beneficiaries by providing more attractive benefits at reduced costs to beneficiaries. Each alternative health plan would receive payment in advance for each enrolled Medicare beneficiary. The prospective payment rate would be 95 percent of what Medicare would have paid for each enrollee in the fee-for-service system.

HCFA has implemented Medicare competition demonstrations throughout the country, including those in Miami, West Palm Beach, and Tampa. In six of the geographic areas, from two to five alternative health plans compete for a share of the Medicare market. In 13 other areas, one AHP will enter the Medicare market for the first time under a risk contract, thus creating a strong impetus for competition effects to take hold.

To date, over 172,000 have enrolled in 26 AHPs already in operation throughout the country. We expect most of these organizations to convert from demonstration status to regular program operation shortly after publication of the final TEFRA implementing regulations.

FLORIDA HMO DEMONSTRATIONS

A particularly interesting study area is Miami, where five HMOs are now competing. To date, these five HMOs have enrolled approximately 30,000 beneficiaries

(nearly ten percent penetration) in less than two years. Two of the HMOs are offering packages with benefits well beyond those normally covered by Medicare such as drugs, eyeglasses, dental services, hearing aids, preventive services, unlimited hospitalization, and elimination of deductibles and copays. These additional benefits are provided at no premium charge to the beneficiary.

Of the other three HMOs, two charge a low premium amount and one recently eliminated its premium altogether, in order to improve its competitive market position.

We attribute the enrollmenit success to the rich benefit packages being offered. All of the HMOs are very active in their marketing campaigns and use local media to present to all Medicare beneficiaries the advantages of their alternative over fee-for-service.

The five HMO demonstrations in Florida are International Medical Centers (IMC), Comprehensive American Care, Incorporated (CAC) (formerly Clinica Association Cubana) Av-Med Health Plan, Health Care of Broward, and Group Health of South Florida. Originally, all plans were approved for operation in Dade and Broward Counties. At the request of several of the HMOs, HCFA approved expansion of their service areas to include Palm Beach and Tampa/St. Petersburg. Presently, a total of approximately 95,000 beneficiaries are enrolled in Florida demonstrations; 30,000 in Miami; 22,000 in Palm Beach; 24,000 in Broward County; and 19,000 in Tampa/St. Petersburg.

IMC

International Medical Centers (IMC) is an HMO serving residents of Dade, Broward, Palm Beach, Hillsborough, Pasco, and Pinellas counties, Florida. IMC is a "federally qualified" HMO in the Miami area and is seeking Federal qualification in the West Palm Beach/Tampa Bay areas. IMC is by far the largest Medicare HMO competition demonstration with regard to enrollment of beneficiaries. IMC currently serves approximately 116,500 members, 80,000 of which are Medicare beneficiaries in the demonstration project. IMC projects Medicare enrollment to reach about 95,000 by the end of 1984, with 60 percent of the new enrollment in the Tampa Bay area. IMC is reimbursed for Medicare enrollment 95 percent of the adjusted average per capita cost in the fee-for-service environment. Its benefit package includes the standard Medicare benefits plus unlimited hospital days, elimination of copayments and deductibles, eyeglasses, hearing aids, prescriptions, preventive tests, and immunizations. There is no premium.

COMPREHENSIVE AMERICAN CARE, INCORPORATED (CAC)

Comprehensive American Care, Incorporated (CAC) is a federally qualified HMO in Dade County and also serves residents of Broward County, Florida.

Current total enrollment is 73,000 with 3,300 members in a Medicare risk demonstration. In the demonstration, CAC offers a Medicare benefit package at no premium cost to beneficiaries eligible for parts A and B, as well as those eligible for part B only. CAC is reimbursed 95 percent of the adjusted average per capita cost (AAPCC) and offers a benefit package including the normal Medicare benefits plus unlimited hospital days, eyeglasses, dental care, prescriptions, hearing exams, transportation, and elimination of copays and deductibles.

AV-MED HEALTH PLAN

Av-Med is a federally qualified HMO in Dade and Broward counties and has a commercial enrollment of 50,000 and 9,000 Medicare enrollees. In January 1984 it expanded its service area to include Tampa/St. Petersburg. The plan offers a comprehensive package to Medicare beneficiaries with both parts A and B coverage. A monthly premium of $35.00 was charged initially. The premium was reduced and finally eliminated in January 1984 to increase the plan's market appeal. In addition to the basic Medicare benefits, Av-Med covers all Medicare deductibles and some coinsurance and provides extended benefits, including prescription drugs, vision care, dental services, and preventive care.

HEALTH CARE OF BROWARD

Health Care of Broward (HCB), an affiliate of HealthAmerica Corporation, is a federally qualified HMO operating in the counties of Broward, Dade, and Palm Beach, Florida. HCB currently has 13,063 commercial and 2,578 Medicare members. HCB receives reimbursement at 95 percent of the AAPCC for Medicare-covered services only. The benefit package includes all Medicare part A and part B services

plus unlimited hospitalization, prescription drugs with $3 copay, eyeglasses, hearing aids, and routine dental care. The monthly premium is $20.

SOUTH FLORIDA GROUP HEALTH

South Florida Group Health (SFGH) is a federally qualified HMO serving residents of Dade and Broward counties, Florida. Current enrollment is 8,500. Enrollment of Medicare beneficiaries only recently started and projected enrollment for the year is 5,000 members. SFGH is a member of the National Risk Reserve System, a demonstration of seven HMOs which are members of the American Medical Care and Review Association. In this demonstration, all demonstration HMOs contribute to a reserve fund to cover individual member losses. SFGH is reimbursed 95 percent of the AAPCC and offers a benefit package including the normal Medicare benefits plus unlimited hospital days and prescriptions with copay and deductibles. The premium charge is $14.

CONCLUSION

In conclusion, we believe that we have implemented a demonstration and experimentation program that offers the potential of having a significant impact on the delivery of health care services. The State of Florida has become one of the most competitive areas in the country in providing alternative health care delivery systems for Medicare beneficiaries. We anticipate that we will be able to learn a great deal about a competitive health marketplace from our Florida demonstration projects. As those demonstration projects conclude, we look forward to a good working relationship with the alternative health plans as they continue to provide services to Medicare beneficiaries under the new TEFRA reimbursement system.

I will be happy to answer any questions you may have.

Mr. MICA. Well, thank you very much.

I think this has been very, very helpful. I appreciate the witnesses being here this morning, and I would like to, out of congressional courtesy, the norm is for the chairman to ask questions first, but since we have two guests in our district, I would like to go to our ranking Minority Member, Congressman Rinaldo.

I'd like to say to Congressman Rinaldo, who commented on the size of this hearing today, that it does appear that it's probably the largest turnout that I've ever seen in the United States for an Aging Committee hearing. I think it does indicate strong interest. I also think you might be interested to know that over 40 percent of the district that I represent is over the age of 65. So there is a great personal interest as well as an important subject.

Congressman Rinaldo.

Mr. RINALDO. I think that a Congressman with a district with over 40 percent of the people over the age of 65 is certainly on the right committee, and you are absolutely doing the proper thing in having this type of hearing here. Once again I want to express the appreciation of everyone here when I say it's something that the citizens obviously wanted.

I listened with great interest to the testimony, pro and con on HMO's, and to put this in perspective, so that I, as someone from another state can get a better view of the situation here, and assuming that this is a representative group of people, I would like a show of hands to see how many are enrolled in HMO's here.

[Show of hands from audience.]

Mr. RINALDO. All right. Thank you.

Now, I would like to know how many people are receiving traditional care, going to your private physician?

[Show of hands from audience.]

Mr. RINALDO. OK.

Substantially smaller number, but we have a good mix.

Let me ask Mr. D'Angio and anyone else who wants to comment on the panel, do you think one reason HMO's are growing is because Medicare isn't effective enough?

Mr. D'ANGIO. I think there are two reasons why HMO's are growing.

First, medicare payments are increasingly decreasing for the individuals; and secondly, supplementary insurance is escalating beyond the capabilities of most senior citizens.

I can give you an example of one insurance company, which I had prior to becoming a member of the Gold Plus Plan, in which in 2½ years, the premiums covering 40 percent of actual cost of doctor's fees cost 300 percent more in 1984, as compared to 1982. This, plus the reduced benefits from medicare coverage certainly makes HMO's more attractive vehicle.

Mr. RINALDO. You wanted to comment?

Mr. CUSTAGE. Yes, please.

I think that the cause is psychological.

A VOICE. Can't hear you.

Mr. CUSTAGE. I think that the cause for the enrollment is psychological. You have Glenn Ford up there saying, "I have a special contract with the Government, and I have a right to give you free of charge doctors' visits, hospitalization, prescriptions, eye glasses, hearing aids, and routine dental care." Things that you never could get from medicare.

Now, as a businessman, let's think for a moment. These people who are coming in, certainly the people that I was with, were enticed into this program by getting something for nothing, and people who are living on very highly controlled budgets where every cent counts, I don't blame them for enrolling, and then they get this charming thing here from Glenn Ford, inside is this important information, and then the followup continuing.

I think it's the duty of the Congressmen to insist that these forms of advertisement have some restraint and control over them and the misrepresentations and the summary of benefits.

Mr. RINALDO. Let me just ask you a quick question, and you can give me a one word answer.

What was the name of the HMO that was involved in the story of the cancer patient?

Mr. CUSTAGE. Gold Plus.

Mr. RINALDO. Gold Plus.

Is that the organization, Mr. D'Angio, that you're on the Advisory Council?

Mr. D'ANGIO. Yes, that's true.

Mr. RINALDO. Could you add any light to the case that he just mentioned, whether or not you're receiving similar complaints from other citizens?

Mr. D'ANGIO. I was not aware of this particular case.

Mr. RINALDO. Could you talk into the microphone?

Mr. D'ANGIO. I said I was not aware of this particular case. Our Advisory Board was not and does not necessarily get to review all cases.

This certainly sounds like a disaster story, but I don't think it's unique or limited to HMO's. There are disaster stories elsewhere in the medical world.

Mr. RINALDO. Thank you, Mr. Chairman.

Mr. MICA. Congressman Smith?

Mr. SMITH. Thank you, Mr. Chairman.

First of all, I say that, obviously, every one of these situations which are detailed by the witnesses, whether they're showing that they had, in fact, had some positive benefit from belonging to an HMO, or there's been a major problem because of dealing with an HMO and the benefits they give or do not give under the contract, only points up the fact as to the very basis of why we're here. That is, there are prevailing and counterprevailing views about what is going on. We are in a rather trying stage because we're giving birth to a large, rather difficult and unmanageable kind of program at the present time.

I want to be very blunt, and I said it at the outset, and I'm going to say it again, I'm extremely disappointed in Mr. Fowler's presentation, which was no presentation at all.

The Health Care Financing Administration in this country is obligated to provide us with information, and of all the people that testified, Mr. Fowler, you didn't say anything.

You are the agency that has probably more documented information than any other of all these people sitting in this room, certainly all of us. All you can tell us is that you're going to open up nationwide demonstration projects to become permanent.

We don't know anything about what you found. You brought us no important news; you brought us no statistics, you brought us no facts; you brought us nothing. You had 5 minutes to summarize, you didn't even take that time, and there are people here who could go on for hours about one individual case.

I find that to be extremely insulting, not only to a congressional committee, but to the people in this room, who are concerned about what's going on, whether they're pro-HMO, neutral on HMO, anti-HMO, doctor, private patient, et cetera.

I have been trying to deal with your office, and my office has been trying to deal with your office for the last year. I'm going to tell you, this is a continuing indication of how callous your regard is for the people of this country.

I don't know who you think is supposed to represent you, but I will tell you that I would like once and for all to get HFCA to give us some information about what this demonstration project really is revealing about providing quality health care to the elderly in this country.

Now, rather than your responding, because it seems to me we're going to talk in terms of overall ethereal matter, let's get into some important questions.

How many beneficiaries are there in this area, in the demonstration projects of medicare that are enrolled in HMO?

Mr. FOWLER. There are 95,000 medicare beneficiaries enrolled in HMO's.

Mr. SMITH. In the State of Florida?

Mr. FOWLER. In the five demonstrations in the State of Florida.

Mr. SMITH. That includes the west coast of Florida?

Mr. FOWLER. Yes.

I wish to apologize if I left the impression that I was not being fully open. In the interest of brevity, I didn't want to make a presentation that duplicated my statement, so I apologize.

Mr. SMITH. Well, people are not going to read your statement, and they would like very much to hear some of the things.

Let's see if we can develop it with questions.

In the last 2 years since the demonstration projects have been on line, and that's about 2 years, correct, August 1982?

Mr. FOWLER. That's correct.

Mr. SMITH. How much statistical data have you developed that you are now using for the purpose to promulgating the rules and regulations at the Federal level that are going to open HMO's around the country to medicare beneficiaries?

Mr. FOWLER. Are you saying these demonstrations?

Mr. SMITH. Yes; and where is that information located and has it been printed, collated, and made available?

Mr. FOWLER. There have been no published studies at this point for the evaluation of the demonstrations. There are contracts that the Government has let to evaluate the demonstrations. The data is being gathered, but at this point, none has been published.

Mr. SMITH. But, HHS is moving forward promulgating the rules which will automatically make these HMO projects available on a nationwide permanent basis, isn't that correct?

Mr. FOWLER. Yes, sir; the Tax Equity Act was enacted by Congress in 1982, and wasn't contingent upon the demonstrations.

Mr. SMITH. That's absolutely correct.

Mr. FOWLER. We have been contracting with HMO's under the medicare program since 1973. We currently have 91 contracts with HMO's.

Mr. SMITH. Is it federally qualified to provide Federal employees with medicare?

Mr. FOWLER. Well, no. There are 300,000 medicare beneficiaries enrolled in 91 different HMO's throughout the country.

Now, most of those contracts aren't like the demonstration contracts, that is, we don't pay on a 95-percent basis, and the HMO does not give significant benefits beyond those covered by medicare.

But, we do have contracting experience since 1973 with 91 plans. The difference in the tax equity provision and the current contracts that we have 10 years of experience in administering primarily deals with reimbursement, and the fact that, under the new law, the HMO's must share with the beneficiaries some of the savings that are generated from the contract, as is the case of the demonstrations here in Florida.

Mr. SMITH. Let me ask you, how many problems have you seen arise as a result, for instance, of enrollment, disenrollment. Disenrollment in my estimation right now, the biggest single cause of problems between HMO's and the medicare beneficiaries that are members of these individual HMO's. I'm talking across the board.

IMC, for instance, may be the largest, but I don't think its problems are any different than any of the other ones; AVMED, or Health Care of Broward, or CAC, or any of the others, so we're talking about HMO's in general.

Is that the biggest single problem of enrollment disenrollment?

Mr. FOWLER. Yes; it definitely is.

We, my office, examined all of the complaints that we have received from the five demonstrations here in Florida.

Mr. SMITH. How many were they?

Mr. FOWLER. For a 1-year period there were a total of 629 complaints that we looked at. We tried to categorize them by type of complaint, which HMO the person was a member of, et cetera.

Of the 629, 577 of those complaints dealt with enrollment/disenrollment practices. You're certainly correct in saying that is the biggest problem and the one we're giving the most attention to.

Mr. SMITH. Whose problems, when it boils down to it, whose problem really was it? Was it a problem of the HMO's or was it a problem of the HMO's and the Social Security Administration computer, not really being able to function correctly at the very outset?

Mr. RINALDO. When you mention 628, I believe?

Mr. FOWLER. 629, sir.

Mr. RINALDO. 629 complaints, out of 95,000?

Mr. FOWLER. Yes; when you consider the complaints in relation to the number of enrollees, that represents about seven-tenths of 1 percent of the enrollees.

Mr. RINALDO. How accurate are the number of complaints? How accurate, do you think there are any complaints that you don't have record of?

Mr. FOWLER. I think that there could be a few that we don't have record of. These are the ones that the demonstration office and my office have received. I have them broken down by the source of the complaint.

We received complaints from beneficiaries, from Congressmen, from Social Security district offices, home health agencies, physicians, lawyers, and hospitals.

Mr. RINALDO. Well, the key things that I want to know is how does that compare with the complaints that you receive involving medicare?

For example, for every 95,000 people?

Mr. FOWLER. I'm sorry, I don't know. I'm not sure—I'm certain my office doesn't have that information; I don't know if HFCA has it.

I will attempt to get it.

Mr. RINALDO. Yes, I'd like to know the number of complaints per 100,000 people in medicare, and I'd like to leave the record open, Mr. Chairman, so that Mr. Fowler will have an opportunity to submit that.

Mr. MICA. We would like to leave the record open. The record will be left open and we request formally that you provide the committee with that information.

[The following material was subsequently received from Mr. Fowler:]

The Health Care Financing Administration (HCFA) does not maintain a centralized Medicare complaint process; thus, data on the number of complaints per 100,000 beneficiaries is not available. Complaints may be made to the contractors who process Medicare claims, but HCFA does not require those contractors to compile statistics and report them. Complaints may also be made to HCFA Regional Offices and handled at that level.

Our concern for beneficiary satisfaction in the Florida HMO demonstrations prompted HCFA to institute a special complaint investigation. We regret that we are unable to provide comparable complaint statistics for the overall Medicare program.

Mr. SMITH. Before I turn it back to the chairman, Mr. Fowler, let me ask you this:

Under the system for complaint, and then possible appeal, that is set up in the demonstration project contracts—when somebody has a complaint with the HMO, they go back to the HMO first, that's correct?

Mr. FOWLER. That's the first place.

Mr. SMITH. Right.

Then would you be involved in that process at all?

Mr. FOWLER. Not at that point.

Mr. SMITH. If it is resolved within the HMO, then it would never come to your attention?

Mr. FOWLER. That's correct.

Mr. SMITH. When you are talking about complaints, it is those that basically did not get resolved at that level, and then went to the next step, which is to have HFCA become involved through some kind of arbitration.

Mr. FOWLER. The majority of these, I must confess, didn't even go through the HMO grievance process. The individuals came directly to us.

Mr. SMITH. Thank you.

Mr. MICA. Thank you.

Mr. Fowler, do you audit, does the Federal Government audit on a regular basis all of the HMO's that are certified by the Federal Government?

Mr. FOWLER. Well, the Federal Government does. That continuing qualification activity, compliance activity, is handled through the Public Health Service in Rockville. The Office of Health Maintenance Organizations does that.

In order to be a contracting HMO under the regular medicare program, the HMO must, under current law, be federally qualified. Under the new TEFRA law, it must be federally qualified or qualified by the Public Health Service as a competitive medical plan.

As part of that qualification process, the Public Health Service does have an ongoing monitoring activity to assure that the organizations continue to meet the requirements of the law.

Mr. MICA. I understand and that's a part of the question, too.

What extent is the auditing and the monitoring cranked into the decision that's been announced that we should move into a national program of HMO's?

Is that being done very carefully on a regular basis? Do you have access to that information?

Mr. FOWLER. Well, sir, I believe that it is being done carefully with proper safeguards.

We work very closely with Dr. Seubold in the Public Health Service, who will be doing the qualifications under the new law on behalf of the Secretary.

The new organizations contracting with medicare as HMO's or competitive medical plans will have to meet the high standards

that any organization wishing to be federally qualified must meet in those areas that the law requires.

For example, under the new TEFRA law, an organization must be financially viable. The Public Health Service will apply the same standards to competitive medical plans as they will to federally qualified HMO's.

Mr. MICA. Let me ask you. According to my understanding, we pay 95 percent of the medicare payment to HMO. Has your auditing revealed that 95 percent is too much or too little?

One of the questions we'll ask the providers, for instance, there has been comment that all the free items that are given, if indeed they can afford to give all these free items, are we paying too much, or are these taken as lead losses, or how do you break that down?

Mr. FOWLER. Well, sir, under the 95-percent reimbursement we do not require the HMO's, nor does the new TEFRA law require HMO's to report their actual costs, or what it actually costs to provide the service.

Mr. MICA. Such as?

Mr. FOWLER. Well, it would be impossible for me to answer that.

Mr. MICA. Well, you're involved in the agency that's making the regulations. If they open HMO's to the entire 260,000,000 Americans, and you have the data, and that's one of the things that we're trying to find out.

I would tell you that that's probably one of the questions, there's constantly a question, "Are they good or bad, and some of the problems," but also, "What are we paying," "Are we paying too much?"

Do you have data that indicates anything to th[illegible] effect, before we make a [illegible]ational recommendation?

Mr. FOWLER. My office does not receive data on the cost of benefits in the demonstration projects, although the demonstrations, I believe, have filed information on costs with HCFA's Office of Demonstrations.

The new TEFRA HMO's are not required to file reports of their costs. The idea is that the Government will be guaranteed a 5-percent savings, and the amount of charges that are permitted to be made are determined by the marketplace, as under the new law, by adjusting the medicare premium rate, based upon the rate charged the general public, and requiring that savings go back to the medicare beneficiaries who join.

I think in the case of the demonstrations in south Florida and considering the extensive benefits that are being returned to medicare people, that both the Government and the beneficiaries are certainly getting their money's worth out of this, but as to exact figures I couldn't respond.

Mr. MICA. All right. I have additional questions.

I note that we're about 7 minutes behind schedule, and I still have 3 minutes allotted for my questions, but I'll summarize, if I may, Mr. Galloway, so that we can continue.

Do you have the right to close down an HMO in Florida?

Mr. GALLOWAY. We have the right, but it would have to be done pursuant to an administrative court order.

Mr. MICA. Have you ever done it?

Mr. GALLOWAY. Have we ever done it?

Yes, sir.

Mr. MICA. For what reason?

Mr. GALLOWAY. Lack of funds.

It could be done under a circuit court order, under the rehabilitation statute which we have that applies not only to insurance companies, but also to the allied lines companies.

Mr. MICA. That would lead me to believe you're monitoring the fund basis in the reserves?

Mr. GALLOWAY. Yes, sir.

Mr. MICA. On a regular basis?

Mr. GALLOWAY. Quarterly basis.

Mr. MICA. All right, last question, Mr. Fowler, did you have the same policy?

Can you do that, and have you ever closed one down?

Mr. FOWLER. Well, we can't close one down. We have the authority to cancel an existing medicare contract.

Mr. MICA. Have you done that?

Mr. FOWLER. No, we haven't, not for cause.

We have terminated some due to mutual consent, but we have not canceled some for cause.

I hope my memory is not failing me.

Mr. MICA. What would cause you to cancel one?

Mr. FOWLER. If we discovered that the HMO is engaging in fraudelent activities as a matter of policy, for example, refusing to enroll medicare people because they were less healthy than others, attempting in a premeditated fashion to mislead beneficiaries concerning their rights under the contract, and things like that.

Mr. SMITH. Mr. Fowler, your HMO demonstration projects provide for mix of medicare to nonmedicare patients, don't they?

If the HMO demonstration project with a specific HMO is discovered to have been violating because the mix is not correct, there's not the number of elderly required to get into the number of the other age groups, would you close them down?

Mr. FOWLER. No, sir; we wouldn't.

Mr. SMITH. I'm talking about the contract. I know you can't close the HMO because they're State-chartered.

Would you take the contract and vitiate it? Would you pull the contract from them, in other words?

Mr. FOWLER. Well, we could, but we certainly wouldn't do that.

In reference to your referral to the 75-percent limit on medicare enrollees, we'd work with that organization once it exceeded the 75 percent to try to get them to comply rather than arbitrarily telling all the people that were enrolled in the HMO that we're going to close the contract.

Our goal would be to get them into compliance, not to terminate them.

Mr. SMITH. How many contract violations would you tolerate or suffer before you might pull a contract for a demonstration project?

Do you have any idea? Is their any written guidelines at all for any way in which you deal with contract demonstration projects?

Mr. FOWLER. There are no guidelines that get to the point of your question, sir.

Mr. SMITH. Thank you.

Mr. MICA. In the interest of time, we're going to have to stop this panel. We have one other panel.

Let me just ask if we can proceed in this order.

First, I would like to thank the Consumer witnesses for being with us, and if you can't stay, that's fine.

If you have to leave, we understand.

Second, I would like the Government witnesses, if at all possible, to remain, or notify us if you have to leave, and third, I will leave the questioning open for my colleagues and myself. We each have a number of other questions, but we may decide to pursue in writing that we would like to have for the official record.

So, with that, I'd like to thank the panel.

Thank you very much, and we'll call up the next panel.

The record is open again, for any written statement.

OK, our next panel is Panel No. 2, providers.

Let me suggest that anyone who would like to converse, there is a beautiful lounge just outside the door to my right. You can step in there.

We'd like to proceed. We are about 5 to 10 minutes behind.

Will the next panel please take their places at the podium. Thank you.

Mr. MICA. May I ask our colleagues and members of the press and the witnesses to please continue in the lounge outside the door?

May we proceed.

Representing the HMO's, we have Mr. Frank Colavecchio, president of Doctor's Office in Coral Gables, Mr. Miguel Recarey, president of the International Medical Centers, and Dr. J. Sanders, senior vice-president for medical affairs, Mr. Jonathan Rose, director of administration of AVMed, Inc.

Physicians, we have Dr. Lee Fischer, president of the Palm Beach Medical Society and Dr. Ernest Sayfie, past president of the Broward Medical Society.

Let me just take a minute right here and tell you what we are not going to do, or put up with, and I don't mean to get a little harsh, but we are going to have to continue.

I know this is an emotional subject for some. If you feel you have to have an outburst, we'd like you to step outside and do that.

Now, we want to hear from everyone. We are going to demand decorum here, this is a congressional hearing, duly authorized. So, right here, before it gets out of hand, we will stop the hooraying and the booing, and everything. We are going to listen to the witnesses, or we will have to stop the hearing.

Now, it hasn't gotten too far out of hand, and we don't want it to.

All right.

To briefly restate, we have Mr. Colavecchio, from Doctor's Office; Mr. Recarey with IMC, Dr. Jay Sanders, vice president of Medical Affairs with IMC; Dr. Lee Fischer from the Palm Beach Medical Society, and Dr. Ernest Sayfie, past president of Broward County Medical Society.

I think we will proceed first with Jonathan Rose, with AvMed, Incorporated.

We will proceed with Mr. Colavecchio, and let me say again, we appreciate everyone being here. We are trying to conduct this hearing to create a record of information, not emotion on HMO's, and we want to proceed on that basis.

Mr. Colavecchio, please proceed.

I will do more than give a warning at 5 minutes.

PANEL TWO: HMO'S AND PROVIDERS, CONSISTING OF FRANK COLAVECCHIO, PRESIDENT, DOCTOR'S OFFICE, INC.; JAMES DOHERTY, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICA; DR. JAY SANDERS, SENIOR VICE PRESIDENT FOR MEDICAL AFFAIRS, INTERNATIONAL MEDICAL CENTERS; JONATHAN ROSE, DIRECTOR OF ADMINISTRATION, AV-MED, INC.; DR. ERNEST SAYFIE, PAST PRESIDENT, BROWARD COUNTY MEDICAL SOCIETY; AND DR. LEE FISCHER, PRESIDENT, PALM BEACH COUNTY MEDICAL SOCIETY

STATEMENT OF FRANK COLAVECCHIO

Mr. COLAVECCHIO. Good morning.

My name is Frank Colavecchio; I live at 610 South Lakeside Drive in Lake Worth.

I am president and chief operating officer of the Doctor's Office, Gold Plus Plan, which operates medical facilities in Boynton Beach, Lantana, Lake Worth, and shortly, in West Palm Beach.

We service approximately 12,000 members, and we are the largest HMO affiliate provider in Florida.

The Doctor's Office currently has seven full-time and five part-time physicians licensed to practice family and internal medicine in the State of Florida. They are assisted by 6 certified physician's assistants, all graduates of the University of Florida Medical School, plus about 45 nurses, 35 nursing assistants, 4 licensed x ray technicians, a full-time radiologist, ophthalmologist, podiatrist, chiropractors, social worker, and various support staff, to a total of 145 full-time personnel.

This equals one staff member per 83 members. We provide 24-hour, 7-day-a-week, regular, and emergency care.

Our patients have access to medical care regardless of the time or the day.

Besides in office care, we provide at-home care with the staff of 12, consisting of nurses, nursing assistants, physical and speech therapists, and homemakers.

The home care unit makes about 250 home visits per week. If these same home visits were provided through the regular medicare program, the cost would be about $43 per visit per monthly total of $43,000.

These very same services are provided by the Gold Plus Plan for $13,200 which includes salary, mileage, and employee fringe benefits.

The same cost savings hold true for physical therapy treatment. The Doctor's Office, under a contract, provides 600 treatments a month, some at patient's homes.

This cost, by an outside agency, would be about $38 per treatment for a total of $22,800 a month. Cost to the Gold Plus Plan is

$20 per treatment, equaling $12,000, and a very substantial savings.

These same savings apply in almost every area. I might point out here that quality is not sacrificed by these cost savings. We take pride in our organization for delivering the highest quality medical care available, certainly in this community, and probably anywhere.

Please do not accept my word for the quality care we provide, but accept the words of the members we serve. I wish to present you with over 3,000 post cards, we call them report cards, that patients have taken time out to fill and return to us over the past several months. Ninety-eight percent of these cards are a positive reaction to the Gold Plus Plan, and there are only 69 negative comments, and we have taken immediate corrective action for them.

Also, at this time, please allow me to present you with a statistical analysis of the type and number of services which the Doctor's Office Gold Plus Plan has provided during the first 4 months of services.

Our critics allege that we try not to provide services because it cost us money. Our statistics are verifible.

I now would like to address several areas that our critics seem to be concerned about.

First, hospitalization. I have a list with me from last week of the members, of our members in the hospital. As you can see, they are not only here in Palm Beach County, but in such places as the Mayo Clinic, the Leigh Clinic, and other similar quality institutions all over the country.

During the first 6 months of this year, we provided about 30 open heart operations at Mt. Sinai Hospital in Miami alone.

We have formed groups of family practitioners and specialists to admit patients to the three area hospitals that we utilize, John F. Kennedy, St. Mary's, and Humana, all quality hospitals.

At this moment, all but two of our patients at those three hospitals are under the care of our physicians. To illustrate the high quality of hospital care, our members receive, let me also present you with unsolicited letters and notes from our members.

Our motto is, 'We dare to care,' and we live with that.

The Doctor's Office has about 50 board-certified specialists in every speciality, and they are all individuals well established and with the highest personal and professional reputations in the community and among their peers. All but one belong to the Palm Beach County Medical Society.

Thirty-five of these specialists are under what we term a prepayment plan. Every Monday they receive a check for what is estimated as one-quarter of what their bills might be for the month. These checks range from $1,000 to $5,000 per week. This plan has met with unqualified success and a greater ease of operation.

My time is almost over, and I would probably, could go on indefinitely.

Let me say the desire of the Doctor's Office is to be the model for HMO's and we are proud of the visitors from all over this country who have come to see for themselves which many regard as the HMO.

Besides reducing the cost of health care for the Federal Government, HMO's have made it available, have made available quality medical care to medicare recipients, and remove many problems and difficulties that have plagued the medicare beneficiary.

What would have happened to the man we had who had to be sent immediately from a local hospital in Philadelphia for a test? It cost us $5,800 to charter an air ambulance, but he is alive and well today, and I could go on and on with incident after incident.

If we were not available, what would happen to these patients? The HMO concept is new to this area, and certainly we are learning daily how to make it work. We are not perfect, but we are striving for perfection.

Please give us that time we need.

In closing, years ago we coined a phrase called senior citizen. It was meant as a term of respect for the people who have worked long and hard to make this the greatest Nation in the world. Today, the term, senior citizen has been given a bad connotation. We are turning our backs on them. We are making our mothers and fathers sound like a burden on society. I beg them to forgive us for this.

Please do not turn away from them. They need this program. Some day you and I may need this program. Please do not let a few greedy individuals impose their will on you. Do not take this last hope away from them.

Thank you.

Mr. MICA. Thank you, and let me just say that I missed one individual who will be testifying, James Doherty, the executive director of the Group Health Association of America, and we will go to Mr. Doherty next.

I might point out, too, that Dr. Sanders will testify on behalf of Mr. Miguel Recarey. Mr. Recarey has submitted a written statement, and that statement will be included in today's record. Finally, the last witness that we have, Dr. Sayfie, I pronounced it Sayfie, and you say Sayfie.

Thank you, all right.

Mr. Doherty, please proceed.

STATEMENT OF JAMES DOHERTY

Mr. DOHERTY. Mr. Chairman, the Group Health Association of America is the major representative of group and staff model HMO's in the country. Our member plans encompass approximately 80 percent of the national HMO enrollment. Our older plans were the pioneers, who over the last 40 years, proved the ability of prepaid organized health care systems to bring high quality, comprehensive, and cost-efficient health care to consumers. The comprehensiveness of our benefits and our cost effectiveness, derive from an emphasis on early access, dependent care, outpatient coverage, and the development of utilization review mechanisms designed to avoid unnecessary hospitalization and unneeded medical procedures. Savings generated by these efficiencies are translated into broader services, including outpatient services and lower out-of-pocket costs to the consumer.

It is no wonder, then, that in these days of disastrous health care inflation, employers, unions, consumers, and Government are actively promoting HMO membership. Our enormous growth over the last few years is reflective of this interest.

For the last 14 years, we led the uphill struggle to bring the advantages of HMO's to the elderly. Medicare, since its enactment, has set a cost reimbursed system for HMO's, thus precluding our ability to pass on savings to the elderly in the same manner that we do for the under 65 population.

Since 1965, HMO enrollment among the elderly has consisted mainly of those who age-in to the medicare program. These aged-in enrollees fill in the medicare gaps and other benefits normally offered by the HMO with supplemental coverages which are paid for by a premium that in many cases, results in considerable financial hardship to persons living on fixed incomes.

The TEFRA amendments, when implemented, will do a great deal to resolve the problem and will generally make HMO's an attractive alternative to the elderly. Calling as they do for equitable medicare payments to HMO's, with the savings mandated to the consumer, the amendments offer great hope to the elderly who are ever concerned over the tragic economic choices and consequences of serious illness and injury.

In Portland, OR, and Worcester, MA, GHAA plans have demonstrated the tremendous human and economic worth of the program. The savings generated under the new system have enabled the plans to absorb the medicare copayments and deductibles, provide full outpatient coverage and 365 days in the hospital, add vision, drugs, hearing, and other uncovered benefits, with as much as a 50-percent reduction in the cost of the supplemental coverage to the individual. It is no wonder, then, that consumer acceptance has exceeded 90 percent in both these locations, and there is a waiting list to get in.

There are now over 300 HMO's in the country who have the potential for qualifying for these new risk contracts. We urge you and your colleagues to support early implementation of the law. This law was a long time in the making, some 14 years, and has been endorsed and worked very carefully on by the last four administrations. The recent medicare cuts in the deficit reduction bill, passed by the Congress 2 weeks ago, lend some urgency to early implementation of this system.

We are aware of the need for safeguards to insure that those who participate in the system, can have a high degree of confidence in the HMO's reliability and integrity. Throughout the 14 years of development of this program, Congress has, we believe, provided a sufficient regulatory environment for the program. Of course, the most important safeguard has been and is the high reputation of HMO's throughout the communities they serve. Independent scientific surveys have confirmed this broad-based acceptance.

In addition, the regulations, which must be distinguished from the demonstrations, will require: Careful adjustment of rates to the demographic mix of our enrollees; dedication of savings solely to the benefit of the enrollee; and, a 30-day right of disenrollment to the consumer. The best way a consumer can express his opinion is with his feet.

Federal oversight of the quality of care and financial viability of the HMO and Federal requirements for the solvency of the HMO: For federally qualified HMO's, the standards include requried medical social services which would prevent the kind of thing that Mr. Custage talked about.

Prescription of inappropriate marketing practices: I agree with the earlier witness, Mr. Stein, that free lunches and that sort of thing should be prohibited. Recently, the chairman of the board of Chrysler Corp., offered a $250 bond to any HMO member who brought in another member. The chairman of the Ford Motor Co., wrote to each employee and explained the advantages and disadvantages to the employee of HMO enrollment. The enrollments, as a result of their open seasons, were higher in Ford, with an intelligent explanation, than they were in Chrysler with the $250 bond.

Careful education of the consumer, as to both the advantages and the disadvantages of HMO enrollment: We in GHAA strongly support this kind of regulatory framework. More importantly, we know that our success depends on our ability to keep the trust of our enrollees, and that trust can only be maintained through informed members.

We are grateful to you for these hearings as a contribution to an informed community.

One final note, Mr. Smith, you criticized Mr. Fowler pretty harshly. I've known Mr. Fowler for the last 10 years, and he has been a tough, but fair regulator. I think the thing that you should understand, sir, is that I share your frustration in many instances, with HFCA and the bureaucy, but your office informs me that their frustration is not with Mr. Fowler's office, but with the Office of Demonstrations.

It is Mr. Fowler's office, the Office of Group Health Plan Operations, that is supposed to respond to complaints, to work with HMO's, to show them how to do things a little bit better. I have always found him to be a fine and capable administrator.

It is the Office of Demonstrations that I submit to you has been the main source of your frustrations, and mine, on these demonstrations.

[The statement of Mr. James Doherty follows:]

PREPARED STATEMENT OF JAMES DOHERTY, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICAN, INC.

Mr. Chairman and members of the Committee, I am James Doherty, Executive Director of Group Health Association of America (GHAA). GRAA represents over 120 prepaid group practice plans a majority of the group and staff model health maintenance organizations (HMOs) in the country. GHAA's member plans serve approximately 10 million members nationally, 80 percent of the total national HMO enrollment. GHAA has a number of member plans in Florida, including CIGNA Healtnplan of Florida, Healthcare of Broward, managed by HealthAmerica, PruCare, South Florida Group Health Plan and Tampa Bay Health Plan.

I am pleased to be here today to discuss the growing role which we believe HMOs will play in providing high quality health care to elderly Americans. The increase in HMO enrollment in the past few years, primarily among employed populations has been impressive and last year averaged 15 percent nationwide. Our popularity has largely been due to our ability, proven over the last 40 years, to achieve significantly lower rates of increase in our premiums than competing indemnity coverages while at the same time continuing to offer comprehensive benefit packages and maintaining quality of care. A review of studies comparing quality of care in HMOs and in other settings, which was performed at Johns Hopkins University, found that

in 19 studies the quality of care in HMOs was determined to be superior to that in other settings; in the remaining 8 quality was either found to be similar or the results were inconclusive; and in no study was the quality of care in HMOs found to be below that in other settings.

With respect to premium increases, a study by the Massachusetts Hospital Association for the fifteen month period ending in March, 1983, showed that health insurance premiums in the state increased 20 to 40 percent annually, while HMO premiums increased only 15 to 18 percent. Indications from GHAA members across the country are that this is not an isolated occurrence. Further, in a fairly recent development, HMO premiums are often lower in absolute terms than those of other carriers despite the more comprehensive HMO benefits.

We believe that HMOs can also bring affordable, comprehensive, high quality health care to Medicare beneficiaries, but in the past the incompatibility of the Medicare reimbursement system with HMO operations has discouraged HMOs from enrolling significant numbers of the elderly. Until passage of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248), the only reimbursement systems for HMOs were cost-based and retrospective, essentially reimbursing HMOs after the fact based upon the volume of services rendered, much like fee-for-service Medicare reimbursement. Since HMOs must deliver or arrange for the delivery of health services, as well as finance that delivery, they develop their budgets prospectively and plan for the facilities and medical and administrative staff necessary to care for their anticipated enrollment. Private sector enrollment is supported by premium amounts set in advance in accordance with budget projections. By accepting the risk for the delivery of comprehensive high quality health services under reimbursement fixed in advance, HMOs create internal incentives for the cost effective use of health care resources. Retrospective reimbursement under Medicare has, therefore, run counter to the basic organizational framework of HMOs and their normal incentives for efficiency.

For this reason, efforts to enact a prospective Medicare reimbursement system for HMOs began in 1965 with the creation of the Medicare program. They were finally successful with the enactment of TEFRA 17 years later, and because of this lengthy development process that statute has been changed to reflect a great deal of practical experience and has been carefully crafted to assure that its purposes are achieved. The TEFRA HMO provision, when finally implemented, will for the first time offer the elderly the full benefits of HMO cost effectiveness and offer HMOs a method of Medicare reimbursement compatible with their operations.

Under the TEFRA risk reimbursement option, HMOs will be reimbursed prospectively at 95 percent of the fee-for-service cost of providing Medicare Part A and Part B benefits in their geographic area, that is 95 percent of the adjusted average per capita cost or AAPCC. The statute further provides that an HMO must calculate its own adjusted community rate (ACR), that is the premium it would need to provide the Medicare benefits to its members. To the extent that the HMO's efficiencies result in an ACR which is lower than the Medicare reimbursement level set at 95 percent of the AAPCC, the HMO must use this savings to provide added benefits to its Medicare members. These added benefits might take the form of buying out the usual Medicare copayments and deductibles and/or providing services not covered by Medicare such as outpatient prescription drugs or eyeglasses. TEFRA provides that in addition to the Medicare benefits and those which are covered by the savings, HMOs may also provide further benefits to their Medicare members for which they would charge a premium. This permits HMOs to offer the same comprehensive benefit packages, with limited out-of-pocket costs, to their Medicare members which they offer to their under-65 members. Medicare beneficiaries who join HMOs under this reimbursement arrangement must agree to obtain all of their health care only from or through the HMO.

In short, Medicare beneficiaries will receive additional benefits; HMOs will be equitably reimbursed; and the government will pay 5 percent less than fee-for-service Medicare costs.

In order to test this reimbursement system, Medicare has entered into a number of demonstration projects. The longest running began enrolling members in 1980 and have been highly successful. At the Fallon Community Health Plan in Worcester, Massachusetts, its 7,200 Medicare members pay a premium of $15 per month for which they receive their Medicare benefits plus a variety of additional benefits at no further out-of-pocket cost. Their benefits include unlimited hospitalization, unlimited primary care physician and specialist visits, all laboratory and x-ray services, prescription drugs, unlimited home care, all medical equipment and prosthetic devices, immunizations, biannual eye exams and eyeglasses.

A survey of Fallon's Medicare members conducted in 1981-1982, showed a satisfaction rate of 99 percent. The HMO has also found the reimbursement system to be successful from an operational standpoint. The plan was small and had no Medicare members when it first embarked on its Medicare demonstration project. Medicare members were enrolled in carefully planned annual increments with the goal of reflecting the same ratio in the plan as in the surrounding community. Fallon's Medicare enrollment is now 15 percent of its membership, and the Medicare population constitutes 16 percent of the community. Fallon has strengthened and improved the internal systems, such as hospital utilization controls, which have been needed for the plan to successfully accept risk-based reimbursement for the provision of care to its Medicare enrollees. The improved systems which have been developed have enhanced the plan's ability to efficiently provide quality care to all of its members.

The Kaiser Foundation Health Plan of Oregon was already a well-established 234,000 member plan which was serving Medicare members under a cost-based contract when it began its Medicare demonstration project. It was permitted to convert 1,800 of its existing Medicare members to the demonstration project and to enroll 5,500 Medicare beneficiaries who had not previously been plan members. This demonstration has also been highly successful for both the beneficiaries (with a 93 percent satisfaction rate) and the HMO.

Currently under the Kaiser project two benefit packages are offered, both of which cover Medicare Part A and Part B benefits and additional services not covered by Medicare. Under the first benefit option for a $5 per month premium benefits include: 1) for no additional charge, complete inpatient and outpatient hospital services, including physicians' and surgeons' services, all laboratory and x-ray, services, and home health services; 2) for a $2 copayment per visit, all outpatient physicians' services, most immunizations, physical therapy and vision and hearing examinations. Under the second benefit option, for a premium of $20.83 per month, enrolled beneficiaries receive a benefit package which includes all of the services just listed plus prescriptions (for a $1 copayment), hearing aids at no charge and eyeglasses at no charge.

Both the Fallon and Kaiser Portland projects have demonstrated that under prospective reimbursement at 95 percent of the AAPCC, HMO efficiencies can produce substantially increased health care benefits for the elderly, protection from significant out-of-pocket costs and uncertainty about physician willingness to accept assignement and freedom from paper work burdens, and that these things can be done within a system that provides high quality, acceptable, and accessible health care. We believe that the general availability of the type of HMO coverage which will flow from the implementation of TEFRA will open up an important new health care option for Medicare beneficiaries at a time when cuts are the order of the day in other aspects of the Medicare program.

There is no question that this can be a good program for the elderly and for the HMOs which participate in it. However, Medicare beneficiaries can be a vulnerable population, and as was the sad result under the PHP (prepaid health plan) program for Medicaid beneficiaries in California in the last 1970s, if such a program is abused, the results can be tragic.

Many lessons have been learned from the PHP experience and subsequent efforts to create safeguards which are not so burdensome or inflexible that legitimate HMOs will not find government programs attractive, but which will provide the oversight and enforcement authority needed to prevent harm to the program's intended beneficiaries. We believe that the protections included in TEFRA and the proposed TEFRA regulations will, if appropriately implemented, insure that this new Medicare reimbursement mechanism for HMOs realizes its great promise. The safeguards range from requirements regarding the structure of the organizations which may participate under TEFRA, to the reimbursement and benefit provisions, to marketing and enrollment standards, and to individual member rights. They have been carefully selected to provide a framework within which the vulnerable Medicare population can successfully be offered a comprehensive prepaid health care option.

First, in order to participate in the TEFRA Medicare program, an organization must either be a federally qualified HMO or meet the standards for a competitive medical plan (CMP), which in more generic terms also describes an HMO structure. The Office of Health Maintenance Organizations (OHMO) will be charged with the organizational eligibility determinations for both HMOs and CMPs. We believe that this is positive, since OHMO has successfully performed the HMO qualification and ongoing compliance function for over ten years. Through this process, federal qualification has become a good housekeeping seal of approval which is widely relied upon by employers, unions and consumers as a sign of viability and structural integ-

rity. We believe that under the final regulations OHMO should apply the same ongoing compliance process to CMPs as will be applied to HMOs.

While establishment of an effective quality assurance program is already a requirement for federally qualified HMOs, under TEFRA it is made a specific condition for entering into a Medicare contract. The same federal HMO standards are applied to both HMOs and CMPs under the proposed regulations and again in this important area OHMO has a track record of overseeing HMO compliance. We believe this argues for a similar role for the agency under TEFRA for both HMOs and CMPs.

Moving beyond the initial organizational requirements for participation under TEFRA, the reimbursement system itself contains a number of safeguards. In order to insure an appropriate level of Medicare reimbursement for enrolled beneficiaries, the AAPCC formula includes adjustments for a variety of characteristics associated with the fee-for-service cost of providing Medicare benefits. These characteristics include age, sex, geographic distribution, disability and welfare status and institutionalization. While the formula is not perfect, and we expect continuing work to improve it, it is adquate to provide appropriate levels of payment to HMOs for their Medicare enrollees without underpayments or overpayments which will seriously disadvantage either the Medicare program, the participating HMOs or enrolled Medicare beneficiaries.

The principle upon which the TEFRA HMO reimbursement system is based is that, due to their more efficient use of health care resources, HMOs will be able to provide Medicare Part A and Part B at less than 95 percent of the fee-for-service cost of these services, or 95 percent of the AAPCC, and that the savings generated can be used to provide added benefits for HMO Medicare members. The adjusted community rate (ACR) is included in TEFRA as the measure of the HMO's efficiency and a way of documenting that savings inure to the enrolled beneficiaries.

HCFA must approve the ACR after determining that it is a fair calculation of the premium the HMO would need to cover the Medicare Part A and Part B benefits. The review insures that the ACR is derived by the same method used to establish premiums for the HMO's under-65 members, with the addition of factors reflecting the expected higher rate of use of services by the plan's Medicare members.

The difference between the ACR and the Medicare reimbursement level set at 95 percent of the AAPCC reflects the savings generated by cost effective HMO patterns of medical practice. This amount must be used by the HMO to provide added benefits to its Medicare enrollees and prior to any benefit year, HCFA must approve the benefits the HMO proposes to offer to insure that they fully reflect the value of the savings.

Further, if the HMO offers benefits beyond Medicare Part A and Part B and those which must be covered by the savings, it can charge a premium for such supplemental benefits. HCFA must approve this amount, as well, to determine that it is calculated in same fashion as the ACR for Medicare-covered benefits. This premium and the specific benefits it covers must be disclosed to the HMO's Medicare members.

We are pleased that TEFRA establishes considerable HCFA oversight authority over enrollment and marketing practices. The key to HMO success over the last 40 years has been the element of informed choice. We are particularly sensitive to the care which must be given to educating the elderly as to all of the advantages and disadvantages of HMO membership. The proposed TEFRA regulations required that an HMO must maintain and provide its Medicare members with written rules regarding how and where to obtain services from or through the organization, disenrollment rights, procedures for paying any out-of-pocket costs, grievance and appeal procedures and other matters. It is critical that this basic information be clearly and readily available to every HMO Medicare enrollee.

Further, all marketing materials directed at Medicare beneficiaries are subject to HCFA review and approval. The proposed regulations list prohibited marketing activities which include use of discriminatory or unethical materials, use of misleading or confusing materials, offers of gifts or payments as an inducement to enroll, and the use of oral or written statements which conflict with, materially alter, or erroneously expand upon the materials approved by HCFA. We believe that these prohibitions will provide effective authority to preclude improper marketing practices, and we are recommending that door to door solicitation, because it is so easily subject to abuse, should be added to this list. Worthy of note, is the special mention in the preamble to the proposed regulations of improper marketing activities as a basis for the termination of an HMO Medicare contract. The preamble points out that HCFA's authority is broad enough to permit termination "if an organization has a repeated pattern of questionable marketing activities, no one of which is itself a cause for termination. . . ."

The marketing materials can be expected to contain a full description of the benefits offered and the scope and conditions of coverage. One of the most difficult conditions to communicate effectively to the Medicare population is that services must either be obtained directly from HMO physicians and facilities or arranged for by the HMO, unless the services are of an emergency or urgently needed nature. The clarity of the marketing materials in this regard is critical, as are ongoing efforts by the HMO to insure that its Medicare members are familiar with the HMO delivery system. The statute and regulations give HCFA effective oversight in these areas.

To insure that Medicare beneficiaries are not only fully informed of their rights and the operation of the HMO's system but that they are satisfied with the services received, one of the most important safeguards in TEFRA is the provision which permits HMO Medicare members to disenroll at any time, for any reason, upon one month's notice to the HMO. Some of the worst abuses which occurred in connection with the California PHP program arose because Medicaid beneficiaries failed to receive adequate health care services but could not leave the prepaid plans in which they were enrolled. Under TEFRA, a Medicare beneficiary who is dissatisfied with services received or lack of access or who simply decides that he or she does not like the HMO system may disenroll at any time.

In a similar vein, an HMO Medicare member who is dissatisfied with health care services provided by or through the HMO or coverage determinations made by the HMO must have access to an internal grievance procedure and has access to a Medicare appeals process comparable to that available to all other Medicare beneficiaries.

The HMO is required to enroll Medicare beneficiaries during an open enrollment period of at least 30 days up to the limits of its capacity. The question of capacity is an important one both with respect to insuring that an HMO makes a fair portion of its capacity for new members available to Medicare beneficiaries and that its capacity for such members is not widely exceeded.

On the one hand, capacity should not be so restricted that HMO membership is not a reasonably available option for the Medicare beneficiaries in the HMO's geographic area. On the other hand, enrollment of more Medicare members than the HMO is prepared to serve can cause unacceptable limitations on access to services, stress on medical recordkeeping capabilities, difficulty in maintaining critical utilization control and quality assurance programs, and other management problems. It is commonly estimated that Medicare members use four times the hospital days per thousand members that under-65 members use, and they, of course, require significantly more health care resources in other respects as well. The impact of enrolling such members in a self-contained comprehensive health care delivery system can be substantial and must be carefully planned and skillfully managed. Under the proposed regulations, HCFA has the authority to negotiate reasonable capacity goals, as well as to oversee the "quality, appropriateness and timeliness" of services delivered.

In summary, we believe that these safeguards and others in the TEFRA statute and regulations provide the basis for successful prospective reimbursement program which will increase the availability of HMOs to Medicare beneficiaries and for the first time will give Medicare beneficiaries the full benefits of HMO membership through comprehensive health care benefits with reasonable and predictable out-of-pocket costs.

We have learned through experience that serious abuses in prepaid systems, whether or not they are HMOs, can do great damage to HMOs nationwide through a quickly operating guilt by association. GHAA and its member plans, therefore, have great deal at stake in urging that standards be put in place which will assure that the TEFRA Medicare program is a success in every organization in which it is instituted. We cannot say that there are no improvements which can be made in TEFRA and its regulations, but we do strongly believe that the oversight, compliance and enforcement authority they contain will provide the basis for a successful program. The sooner their safeguards are implemented, the better will be the opportunity to establish a positive track record for this much needed program.

Our members are eagerly awaiting the availability of the permanent prospective reimbursement program for HMOs under TEFRA in large part due to the impressive experience of the Fallon Community Health Plan and Kaiser Foundation Health Plan of Oregon. HMOs can indeed offer broader benefits to Medicare beneficiaries for their health care dollars under such a system, and affordable, high quality comprehensive health care is more important to the elderly than ever before as inflation and benefit reductions erode their available funds. To put the TEFRA program in place and assure its success will be one of the most positive contributions to

the nation's health care system in this decade. We look forward to supporting that effort.

Mr. MICA. Our next witness is Dr. Jay Sanders, the senior vice-president for medical affairs.

Dr. Sanders.

STATEMENT OF DR. JAY SANDERS

Dr. SANDERS. Thank you.

Congressman Mica, Congressman Rinaldo, Congressman Smith, before making my formal remarks, I would like to say something specifically apropos to the comments made by two of the consumer witnesses.

I think it is critical to state that IMC does not condone, nor will it ever justify any mistreatment on the part of any patient, whether that mistreatment is an administrative problem, or whether that mistreatment relates to a medical problem, and we have instituted in an attempt to avoid these type of problems, a membership satisfaction assurance program, in which regardless of what the particular complaint may be, a single telephone number may be accessed, and that individual can get that problem resolved within a 48-hour period of time.

We are a large organization. The organization is made up of people, systems, rules, and regulations, and there are going to be problems, and we have problems, but we are committed to making sure that those problems are resolved.

As you noted, I am senior vice-president of medical affairs at International Medical Center. I am also clinical professor of medicine at the University of Miami's School of Medicine and was formerly chief of medicine at Jackson Memorial Hospital, and director of medical affairs at Mt. Sinai Hospital.

Our objective today is to provide a forum to exchange views on the relative merits of an important innovation in medical care delivery, the HMO. While it has only been recently introduced as an alternative health care system, within the south Florida community, the HMO has been in existence since 1929. Its initial growth was slow because of unfamilarity on the part of the public, an attitude of benign neglect on the part of the academic community, but predominantly as a result of intense opposition on the part of organized medicine. However, the HMO has recognized rapid expansion within the past decade. Concerned by the ever-escalating costs of health care resulting in inability of many to afford needed health care, and encouraged by the results of numerous studies, documenting the quality and cost effectiveness of HMO's, Federal legislation has subsidized and the corporate and public sector have encouraged their growth and development.

How does the HMO differ from traditional methods of health care delivery? What are its characteristics?

The HMO assumes a contractual obligation to provide health services to a voluntarily enrolled patient population. Patients pay a fixed fee, thus assuring them in advance that all medical and surgical care, hospitalization, diagnostic laboratory tests, x rays, and all other medical expenses will be covered.

By placing the HMO under financial risk, there is an incentive for cost effective care. The HMO encourages health maintenance, emphasizing preventative approaches to health care. Special programs for risk factor identification and reversal are supported.

The HMO, by neutralizing the economic barriers to health care, tends to foster more accessibility to medical care.

A study done recently by the Arthur D. Little Co. of Cambridge, MA of the IMC HMO demonstrated that we had one and-a-half times more health center ambulatory visits per person than the average ambulatory delivery system in the country, and by improved accessibility, one is able to potentially identify disease processes at an earlier, more treatable stage.

In many HMO's, medical services and records are kept in one place, and you have access to a team of physicians on site, thus centralizing the health care system to allow for greater efficiency, continuity, and availability of care.

Concerning grievance procedures, in contrast to the traditional health care system, elaborate grievance procedures are available, and in fact, required by federally qualified HMO's such as IMC.

In Minnesota, which allows HMO members to appeal their complaints to the State department of health, an average of only 10 complaints per month are received from the 452,000 Minnesotans who belong to HMO's. A similar level of satisfaction was recently corroboratcd by an independent study by the University of Miami relating to the level of satisfaction of IMC patients. A complete copy of that study has been submitted to this committee, but in summary, I would like it clearly stated that over 95 percent of the patients indicated their satisfaction with the care received.

Now that some of the advantages have been noted, we need to clearly address the criticisms that have been and continue to be levied predominantly by organized medicine. The major concern centers around the concept that because the incentive in an HMO is cost-effectiveness, there has to be an inevitable reduction in the amount of medical care delivered, and therefore, a concomitant reduction in the quality of care delivered. I think it should be evident that less quantity cannot be equated with less quality; in the same way that over-utilization and excessive costs which characterize many aspects of the traditional fee for service delivery system cannot be equated with higher quality care. As was previously pointed out, IMC does more ambulatory care per person than the nationwide average, and it is probably this emphasis on ambulatory care that avoids excessive hospitalization and the spiraling costs related to that system. In 1982, the president of the Los Angeles County Medical Association stated, "HMO's will send you for a second, third, fourth opinion until you drop out. They don't want the sick; they want the working well. It's who can deny the most care for the greatest profit." First of all, it seems somewhat ironic that a spokesman for the medical care delivery system that has been identified as the major cause for the spiraling economic costs of our present health care in this country, is accusing the HMO of trying to obtain excessive profits. Second, it should be noted, as an example, that IMC HMO has a patient mix which is greater than 60 percent over age 65 which every medical expert will agree represents a patient mix that requires the most health care services.

39-042 O—84——5

Regarding the quality of medical care provided by HMO's, two significant studies have been published. In 1980, Dr. John Williamson of Johns Hopkins School of Public Health reviewed every evaluation of HMO quality done between 1958 to 1979. He selected only those studies that met the criteria for scientific soundness. Each study had to compare care received by HMO members with care received by a comparable population in the fee for service system. Dr. Williamson found 27 studies that met that criteria. In 19 studies, the quality of care in HMO's was found to be superior to that in other settings. In the remaining eight studies, either quality was found to be similar or the total study findings were inconclusive. Most importantly, in none was the quality of care in the HMO's below that of other settings. Another conclusion of the study was that the quality of care was better for the poor and those with high medical needs in comparison to that provided to a similar population in the non-HMO setting.

A second study conducted by the American Medical Association's Council on Medical Service in 1980, not only looked at previous studies of HMO's, but conducted its own extensive review of 15 HMO's. In view of the AMA's reluctance to endorse the concept of HMO's, the council's conclusions take on added significance. "To the extent that various factors used in quality assessment have been used to measure care for HMO enrollees and for a comparable fee for service population, the medical care delivered by the HMO's appears to be of a generally high quality. The HMO approach, where viable appears to have the potential to provide health care of acceptable quality at a lower total cost to enrollees than many other health care systems."

Most importantly, and of particular significance relative to the major criticism heard from the traditional fee for service system, was that nothing in the literature indicates that HMO savings result from enrollees receiving less care than they need.

Thus, neither of the studies confirm the perception that HMO's do not attract doctors of as high a quality as does fee for service medicine. And, in fairness, it does not confirm that the average physician within an HMO is different from the average physician in the fee for service area. However, all HMO's must be consistently cognizant of the fact that quality of care and utilization of services, in particular underutilization, needs to be constantly monitored. At IMC/HMO, a unique quality assurance program that goes beyond what is traditionally required, has been developed. Headed by Dr. Eugene Komrad, who is a medical director of the Dade County Professional Standards Review Organization, IMC's program incorporates an extensive internal peer review system with a comprehensive external auditing process in which a team consisting of a physician, nurse-practitioner, and administrator evaluates every aspect of the ambulatory health care delivery system of each of our providers. The team examines charts for appropriateness of medical care, the administrative functioning of the office, and the physical condition of the facility. A copy of the audit survey document is included in the material presented to this committee.

This comprehensive procedure is similar to what the Joint Commission on Hospital Accreditation requires to ensure that all hospitals meet a certain high standard, and is the only system of its

kind to examine what goes on in the individual physician's office. This ambulatory auditing procedure is never done by any regulatory body in the fee for service medical delivery system. Parenthetically, it should be noted, and is perhaps obvious, that a major incentive in a system that attempts to be cost effective is to obtain the highest quality of physician. A poor physician will lead to higher, not lower, costs. I am sure that it is also apparent that if an HMO like IMC identifies a physician who is not meeting its standards, it can and it has dismissed that physician. The irony is that once dismissed from the HMO, no one takes his or her license away. That physician is now caring for patients in the fee for service world.

There is an obvious, perhaps understandable, fear on the part of organized medicine of the HMO, similar to their early opposition to group practices, which now flourish, and to medicare, which now flourishes.

Mr. MICA. Would you please summarize, 30 seconds.

Dr. SANDERS. Yes, I will.

The HMO movement is not trying to replace the fee for service practice of medicine. It is asking for an opportunity to demonstrate that it has a role in our health care delivery network. Many of its systems for hospital utilization control and ambulatory rather than hospital evaluation have, in essence, been adopted by the Government in the enactment of the DRG regulations.

Rather than opposing it for the wrong reasons, it should first be tested fairly. At the very least, the same criteria that are being utilized to evaluate the HMO, should be applied to the fee for service delivery system.

Thank you.

[The prepared statements of Dr. Jay Sanders and Mr. Miguel Recarey, Jr., follow.]

PREPARED STATEMENT OF JAY H. SANDERS, M.D., SENIOR VICE PRESIDENT FOR MEDICAL AFFAIRS, INTERNATIONAL MEDICAL CENTERS

Our objective today is to provide a forum to exchange views on the relative merits of an important innovation in medical care delivery—the HMO. While it has only recently been introduced as an alternative health care system within the south Florida community, the HMO has been in existence since 1929 and is now represented by 300 prepaid programs serving over 15 million people throughout the United States. Its initial growth was slow because of unfamiliarity on the part of the public, an attitude of benign neglect on the part of the academic community, but predominantly as a result of intense opposition on the part of organized medicine. However, the HMO has recognized rapid expansion within the past decade. Concerned by the ever-escalating costs of health care resulting in the inability of many to afford needed health care, and encouraged by the results of numerous studies documenting the quality and cost-effectiveness of HMOs, federal legislation has subsidized and the corporate and public sector have encouraged their growth and development.

How does the HMO differ from traditional methods of health care delivery? What are its characteristics?

1. The HMO assumes a contractual obligation to provide health services to a voluntarily enrolled patient population. Patients pay a fixed fee, thus assuring them in advance that all medical and surgical care, hospitalizations, diagnostic laboratory tests, x-rays and all other medical expenses will be covered.

2. By placing the HMO under financial risk, there is an incentive for cost-effective care.

3. The HMO encourages health maintenance emphasizing preventative approaches to health care. Special programs for risk factor identification and reversal are supported.

4. The HMO, by neutralizing the economic barriers to health care, tends to foster more accessibility to medical care. A study done by the Arthur D. Little Health Systems Division of the IMC/HMO demonstrated that we had one and one-half times more health center ambulatory visits per person than the average ambulatory delivery system in the country. And by improved accessibility, one is able to potentially identify disease processes at an earlier, more treatable stage.

5. In many HMOs, medical services and records are kept in one place and you have access to a team of physicians on site, thus centralizing the health care system to allow for greater efficiency, continuity, and availability of care.

6. Grievance Procedures—In contrast to the traditional health care system, elaborate grievance procedures are available and in fact required by federally qualified HMOs such as IMC. In Minnesota, which allows HMO members to appeal their complaints to the State Department of Health, an average of only 10 complaints per month are received from the 452 thousand Minnesotans who belong to HMOs. A similar level of satisfaction was recently corroborated by an independent study done by the University of Miami relating to the level of satisfaction of IMC patients. A complete copy of that study has been submitted to this Committee, but in summary I would like it clearly stated that over 95% of the patients indicated their satisfaction with the care received.

Now that some of the advantages have been noted, we need to clearly address the criticisms that have been and continue to be levied predominantly by organized medicine. The major concern centers around the concept that because the incentive in an HMO is cost-effectiveness, there has to be an inevitable reduction in the amount of medical care delivered, and, therefore, a concomitant reduction in the quality of care delivered. I think it should be evident that less quantity cannot be equated with less quality; in the same way that over-utilization and excessive costs which characterize many aspects of the traditional fee for service delivery system cannot be equated with higher quality care. As was previously pointed out, IMC does more ambulatory care per person than the nation-wide average, and it is probably this emphasis on ambulatory care that avoids excessive hospitalization and the spiraling costs related to that system. In 1982, the President of the Los Angeles County Medical Association stated "HMOs will send you for a second, third, fourth opinion until you drop out. They don't want the sick; they want the working well. It's who can deny the most care for the greatest profit." First of all, it seems somewhat ironic that a spokesman for the medical care delivery system that has been identified as the major cause for the spiraling economic costs of our present health care in this country is accusing the HMO of trying to obtain excessive profits. Second, it should be noted, as an example, that IMC/HMO has a patient mix which is greater than 60% over age 65, which every medical expert will agree represents a patient mix that requires the most health care services.

Regarding the quality of medical care provided by HMOs, two significant studies have been published. In 1980, Dr. John Williamson of Johns Hopkins School of Hygiene of Public Health reviewed every evaluation of HMO quality between 1958 to 1979. He selected only those studies that met the criteria for scientific soundness. Each study had to compare care received by HMO members with care received by a comparable population in the fee for service system. Dr. Williamson found 27 studies tht met the criteria. In 19 studies, the quality of care in HMOs was found to be superior to that in other settings. In the remaining 8 studies, either quality was found to be similar or the total study findings were inconclusive. In none was the quality of care in HMOs below that of other settings. Another conclusion of the study was that the quality of care was better for the poor, and those with high medical needs in comparison to that provided to a similar population in the non-HMO setting.

A second study conducted by the American Medical Association's Council on Medical Service in 1980 not only looked at previous studies of HMOs but conducted its own extensive review of 15 HMOs representing a cross-section of size and location. In view of the AMAs past reluctance to endorse the concept of HMOs, the Council's conclusions take on added significance. "To the extent that various factors used in quality assessment have been used to measure care for HMO enrollees and for a comparable fee for service population, the medical care delivered by the HMOs appears to be of a generally high quality. The HMO approach, where viable appears to have the potential to provide health care of acceptable quality to a lower total cost to enrollees than many other health care systems." Most importantly, and of particular significance relative to the major criticism heard from the traditional feed for service system, was that "nothing in the literature indicates that HMO savings result from enrolles receiving less care than they need."

Thus, neither of the studies confirms the perception that HMOs do not attract doctors of as high a quality as does fee for service medicine. And, in fairness, it does not confirm that the average physician within an HMO is different from the average physician in the fee for service area. However, all HMOs must be consistently cognizant of the fact that quality of care and utilization of services—in particular under-utilization—need to be constantly monitored. At IMC HMO a unique quality assurance program that goes beyond what is traditionally required has been developed. Headed by Dr. Eugene Comrad, who also is Medical Director of the Dade County PSRO, IMC's program incorporates an extensive internal pre-review system with a comprehansive external auditing process in which a team consisting of a physician, nurse-practitioner, and administrator evaluates every aspect of the ambulatory health care delivery system of each of our providers. The team examines charts for appropriateness of medical care, the administrative functioning of the office and the physical condition of the facility. A copy of the audit survey document is included in the material presented to this Committee. This comprehensive procedure is similar to what the Joint Commission on Hospital Accreditation requires to ensure that all hospitals meet a certain high standard and is the only system of its kind to examine what goes on in the individual physicians office. This ambulatory auditing procedure is never done by any regulatory body in the fee for service medical delivery system. Parenthetically, it should be noted, and is perhaps obvious, that a major incentive in a system that attempts to be cost-effective is to obtain the highest quality of physician. A poor physician will lead to higher, not lower, costs.

I am sure that it is also apparent that if an HMO like IMC identifies a physician who is not meeting its standards, it can, and it has, dismissed that physician. The irony is that once dismissed from the HMO no one takes his/her license away. That physician is now caring for patients in the fee for service world. From a strictly theoretical standpoint, let us assume that organized medicine had the authority to immediately dissolve IMC as a delivery system. Where will the physicians who were in IMC now be? That is correct—in the fee for service delivery system. And who will be watching what they do in their office?

There is an abvious, perhaps understandable, fear onthe part of organized medicine of the HMO, similar to their early opposition to group practices, which now flourish. The HMO medical delivery system has grown rapidly. It has diminished the patient population of many fee for service physicians and thus has resulted in a reflex antagonism generated predominately by economic concerns but voiced as quality issues. This reaction is similar to what has been seen around the country when any HMO is introduced into a community as an alternative health care system. Physicians who want to participate have actually been threatened by their colleagues not to join or they will not receive consultations from them. Hospitals, inthe past, under pressure from their medical staff, have at times refused admission to HMO enrollees except in emergencies. Leadership rolls in county medical societies have been denied physicians as a result of their participation.

IMC, like many HMOs, when it first got started had difficulty attracting as many of the type of physicians it wanted because of general resentment by the physicians of the concept. In a fashion IMC was placed in a Catch 22 position. Physicians, who were quality physicians, refused to join and then pointed a finger at us and said we did not have quality care. Despite this we have been successful. And as is now evident by the participation of the physicians who head up our quality assurance program and who are our chiefs of our various departments we have demonstrated our commitment to quality care.

The HMO movement is not trying to replace the fee for service practice of medicine. It is asking for an opportunity to demonstrate that it has a roll in our health care delivery network. Many of its systems for hospital utilization control and ambulatory rather than hospital evaluation have in essence been adopted by the government in the enactment of the DRG regulations. Rather than opposing it for the wrong reasons, it should first be tested fairly. At the very least, the same criteria that are being utilized to evaluate the HMO should be applied to the fee for service delivery system. A motion generated criticism should be replaced by comparative scientific studies. Physicians who oppose the system should first participate in it to see if the system actually causes them to deliver a lower quality of care. We can no longer afford the luxury of our present system. If there are no viable alternatives that attempt to provide quality care within a cost-efficient framework, these hearings in the next few years will be debating the agonizing question of who should be kept alive, because there will not be the money to offer that opportunity to everyone. If you think I am exaggerating the situation, please look at the English system where kidney dialysis is not offered to patients over the age of 65.

I thank you for the opportunity of sharing my thoughts with you today.

PREPARED STATEMENT OF MIGUEL RECARREY, JR., PRESIDENT OF IMC (INTERNATIONAL MEDICAL CENTERS-HMO)

IMC started as a State HMO 12 years ago. It was acquired by present management in 1978 and in late 1980 obtained Federal Qualification. There were no loan guarantees or grants requested from the government.

IMC is the only HMO in Florida that owns its own hospital—Miami General Hospital—a 350 bed medical center located in Dade County. We also contract with additional hospitals in Date County as well as other hospitals in the various counties that we serve. In addition, IMC has selected Blue Cross as its intermediary to pay any hospital that IMC does not have a contract with. This insures that our Medicare members will have access in case of emergency to the nearest hospital at all times. IMC was the second HMO in the nation to enter into a Medicare Risk Contract. This took place in January, 1982. Furthermore, IMC was the first HMO in Florida to enter into the Demonstration Contract with HCFA, which contract started on or about August, 1982.

I must make a parenthesis, and add a positive note regarding the professionalism of HCFA in all matters relating to our HMO and the State Insurance Commissioner's office.

After IMC was granted its Demonstration Contract, HCFA felt that it would be healthy to have competition in the south Florida area. Four other HMOs came into the market a few months after IMC. We feel it was a healthy move since we at IMC believe in competition.

We have a commitment to excellence. Today we also have with us our Vice President of Medical Affairs, Dr. Jay Sanders, a former member of the faculty at Harvard Medical School and Professor of Medicine at the University of Miami; former Chief of Medicine at Jackson Memorial Hospital; former Medical Director at Mount Sinai. Dr. Sanders is in charge of the IMC medical staff and related medical operations as well as the implementation and continuing enhancements to our unique quality assurance program.

The counties in Florida where we are presently rendering services to Medicare beneficiaries are: in the East—Dade, Broward and Palm Beach Counties. In the West—Tampa, St. Pete, Hillsborough, Pasco and Pinellas Counties.

IMC has 7 wholly owned medical centers, approximately 10 in joint venture mode and over 130 private physicians offices as part of our delivery network. IMC is the largest HMO In Florida. We have also the largest Medicare enrollment of any HMO-demonstration contract in the nation. We have presently enrolled close to 90,000 Medicare members which represents approximately 85% of all South Florida Medicare enrollment. This is important, so that IMC's percentage of complaints and any other matters are kept in its proper perspective.

In addition, we have approximately 40,000 commercial enrollees, which means that we are servicing approximately 130,000 members. IMC is twice as large as the next HMO in the State of Florida. Our members are served by nearly 1,200 physicians and 3,500 employees. Glenn Ford is our spokesman for the Medicare program.

We feel that the research component of IMC's Demonstration Program is unique and very important. IMC is committed to research with HCFA, and plans to continue in the forefront of HMO research in this area. We are enclosing herewith, independent research studies conducted under the direction of Richard Langendorf, Ph.D. from the University of Miami. One has to do with patient satisfaction, another with reasons for disenrollment, and the third one with enrollment decision process.

Regarding patient satisfaction, I encourage you to read the reports or the Executive Summary page showing that nearly 95% of the IMC members report satisfaction, vs. less than 3% who report various levels of dissatisfaction. Pertaining to the reasons for disenrollment, approximately 70% of disenrollments are a combination of moving out of the area and wanting their own physicians. Of those who disenroll, and this is very important, 84% indicated they were very satisfied, or somewhat satisfied with the plan. These figures can be found on Page 11 of the second report. These figures are very impressive, where we realize that the over 65 population is very demanding and experienced in many aspects of the health care delivery system in America.

In reference to the enrollment decision, I think that you would be interested to know that 63% of IMC members learn of the plan through friends, etc.; 19% through T.V. and 11% through newspaper. This totals 93% of our enrollment. The remaining 7% balance, learn of IMC by either physicians or other members of the medical profession.

One important element of the research is the specific enrollment and disenrollment processing. In order to address this area, IMC is the first HMO in the nation which has contracted with HCFA and Compuserve providing on-line instant access to the Social Security Computers effective June, 1984. This on-line communication will insure:

(1) A quicker enrollment/disenrollment process.

(2) To more accurately be able to inquire into the Social Security computers, prior to enrolling a member, and find out if maybe a Medicare number is wrong, or the person is ineligible for any reason, the extent of Medicare eligibility, or is presently enrolled in another plan, etc., prior to submitting these to HCFA.

Up to now, many of the above reasons resulted in rejections by HCFA for members that both the HMO and the member thought eligible. A significant amount of confusion has resulted in the past regarding status of enrollment or disenrollment that will now be eliminated.

Benefit packages: We are enclosing a benefit package for the Gold Plus Plan. It is our original benefit package, and we have not changed it from the way it was started. This package is a no-premium, no-deductible, and no-copayments plan. It is a very comprehensive program that provides our senior members with tremendous benefits: No co-insurance and deductibles; no limit on inpatient hospital days; pharmacy prescriptions at Eckerds or Walgreens stores; a comprehensive dental program; two pair of glasses a year; thanks to Senator Pepper, hearing aids . . . We also provide transportation to and from the center when medically necessary. All at No Cost to the Medicare members of our plan. It is very important in counties where the seniors have a need for transportation when medically necessary because of the expense it means for them.

As far as we know, we are the only HMO that explains after an enrollment application is received and signed by the senior, the lock-in provision. We call each and every applicant and explain to them, after receiving a signed application, that we do have a provision whereby members are restricted to service by our physicians and our staff except in case of an emergency. And at that time, 6% of those who have signed applications with us decide not to join and say that they misunderstood and they do not want to be members. This step alone shows the commitment of IMC to assist its members.

IMC is saving approximately ten million dollars a year to the government, plus administrative and claims processing costs that are very significant. As membership increases, so will the savings increase.

Regarding premiums, there are none at IMC for Medicare members. None whatsoever stated, none whatsoever hidden. We feel it is very important that we do not promise anything we cannot provide. This is perhaps one of the reasons of our success. We do not get into a situation where prior approval was necessary. We do not say there are no premiums for the senior to later find out that there are a number of co-payments. As a matter of fact, we encourage our members to visit our medical centers at no cost per visit.

However, we understand that the HMO is not for everyone. Not everyone believes in early detection and preventive medicine.

We invite you to tour our facilities, our central offices. Please contact Dr. Angel Alvarez or myself if you would like to have the opportunity to visit with us.

Mr. MICA. Thank you.

Our next witness is Jonathan Rose, director of administration, AvMed, Inc.

Mr. Rose, will you please proceed?

STATEMENT OF JONATHAN ROSE

Mr. ROSE. AvMed thanks the Congressman for the invitation.

As an introduction, we would like to state, though, that Palm Beach is a bit new for us. Although we are operating under the same charter as the demonstration grant, and are equally federally qualified, Palm Beach, for us, is a new and growing concern, as well as a new endeavor.

We are just now looking at the Palm Beach market. We are just now understanding what the concerns are in Palm Beach, both on the hospital side and on the physicians' side, and it's why we were

so eager to attend this meeting to get a full grasp of some of the situations or issues that we're contending in Palm Beach County.

There are three issues that I would like to touch on briefly. First, it's a bit surprising that no one has addressed an issue that regards HMO's, that AvMed is certainly dedicated to, and the concept I'm speaking of wellness versus illness.

At AvMed we are not a staff model or clinic model. We are solely predicated on what's called an IPA, Individual Practice Association, which is a group of physicians who deliver health care out of their own offices.

Our physician enrollment in this area is quite large in Dade and Broward. We have found a continuation of care to the patient at this level, very conducive both to the patient's care and the patient's understanding of what an HMO is. Many times patients do not have to leave their family physician that they have known for some time; instead, they can continue that care in that physician's office.

We are committed to this, and we have found that in the past, patients truly enjoy this role, truly enjoy seeing the same physician in the same surroundings.

The wellness versus illness issue, of course, is a lot of what the HMO's are predicated on. The availability to go to your physician, at either a nominal or no cost content, to receive care at the first sign of concern of illness.

Again, following the fundamental beliefs that you are more comfortable with your own physician and your own physician has a continuation of history of your care, we have found that, in fact, we are preserving the wellness concept quite nicely. Many times people, patients, who are not feeling well can now afford going to their physician, who has been their physician for some time in their own office, and simply receive one or two tests, and many times alleviate the need for hospitalization, especially when you're concerned with the 65 and over. It's an easy route to treat an influenza at home, rather than to diagnose pneumonia in the hospital. Of course, all HMO's are predicated on this, and all HMO's truly believe that this is the way to deliver care.

We've taken it one step further in being completely involved with, and completely dedicated to the concept of letting the physician practice his or her care in his or her office. We find that both comfortable to the physician and to the patient.

In terms of moving into Palm Beach County, AvMed is very interested and very concerned, and is also on a fact finding mission, as it were, to understand what makes Palm Beach a bit unique. I think it is a bit unique in terms of how it's receiving, from what I've heard today, the HMO concept.

It does not waiver our interest in Palm Beach at all, however, it permits us to understand some of the unique needs within Palm Beach County.

As a summary to our position at AvMed, we do see a movement into Palm Beach County in the very near future. We will move into Palm Beach County, though, not with a staff model, but with our IPA model, permitting individual physicians to treat patients in their own offices.

Third, our movement into Palm Beach County, with the help of this hearing and the understanding of what makes this county unique, hopefully, will permit us to do it with some ease and some quality care, that I'm sure all HMO's are dedicated to.

In summary, we thank you for the time you've afforded us.

Mr. MICA. Thank you, very much.

Our next witness is Dr. Ernest Sayfie, past president of the Broward Medical Society.

STATEMENT OF DR. ERNEST SAYFIE

Dr. SAYFIE. Thank you very much, Mr. Chairman. I'm Ernie Sayfie, a physician in Broward County and past president of the Broward County Medical Association. Presently, I'm chief of staff at Memorial Hospital of South Broward District of Broward County.

Honorable Congressmen, U.S. House of Representatives, designated guests, my physician colleagues, and friends: It is very difficult to describe a general perspective of HMO's today in 5 minutes. That's been readily shown. It is more difficult to understand the multitude of forces that focus on and have an effect upon HMO's and other health care delivery systems that are developing in America today. Therefore, today, I have chosen to outline some of the problems and effects of health care and how HMO's fit into that scenario.

The facts that we have to depend upon, or the premises are as follows. First, health care costs are high.

Inflation, technology, and professional liability problems are the major reasons for this. Also attributed to this is an increase in the number of physicians in this country. Believe it or not, 21 percent are foreign medical graduates today practicing medicine today as licensed physicians in America.

Second, Government, industry, and the people of this country cannot deal with the increased indices of health care costs.

Third, organized medicine is having difficulty in dealing with, or solving the problems of increased health care costs, and finally, fourth, the aging population is getting larger; it needs more attention and better care, especially in the posthospital area that it's getting today.

The actions or the reactions to the above facts or premises are as follows:

First, prospective payment systems have been formed both by government and industry.

Second, the Government has developed the DRG's, which stands for diagnostic related groups, and PRO's, which stands for peer review organizations to control the utilization of health care. The Government also has supported HMO's.

Third, health care coalitions have been formed to produce PPO's, which stands for preferred provider organizations.

Fourth, entrepreneurs have formed the HMO's with the help of the Government.

Fifth, organized medicine has chosen to freeze fees and wishes to be the patient advocate with a high quality of care being delivered to patients at reasonable costs.

Now, the result of all of the above are as follows:

First, prospective payment systems generally guarantee care at a fixed rate, but quality of care is overlooked and never guaranteed.

Second, the Government, and you are the Government, gentlemen, has a financial fiscal problem, and a fiduciary problem as well. The Government is running out of money to render care of any quality to the people for whom it has the fiduciary responsibility and it is searching for systems, and hoping that the PPS's, the DRG's, the PRO's, the HMO's will help. Demonstration HMO's have been established as a means to possibly reduce costs. The verdict is not in as yet.

Third, health action coalitions have been formed. The chief executive officers of leading corporations throughout this country have thrust themselves into the area of health care costs and formed health action coalitions in order to understand why health care costs are rising. They do not know what to do, but they are looking, and that's the thing to do. They have decided to become more involved in the governing bodies of hospitals in order to help control the costs, because approximately 65–70 percent of health care costs are at the hospital level where the doctors write orders for 75–80 percent of these costs. The PPO's were formed to guarantee discounts on health care delivery, with the high quality and efficiently run hospitals and medical staffs. Thus far, the viability of this approach has not been validated by any credible source.

Fourth, the HMO's. Because of the Government interest in solving the problem of health care costs, they have given financial aid and financial sponsorship to the HMO's. Astute businessmen, whose motivation is bottom-line profit, devised a method whereby a generic health insurance policy for industry and private citizens, including medicare participants could be delivered. I call this generic because patients do not have their usual free choice of medical practitioners and medical facilities, and they lose the ability to get an unbiased second opinion. Remember, gentlemen, this is America and not England. We, in Broward County, both hospital providers and physician providers, who have tried to cooperate with the HMO's, are disappointed, discouraged, and dismayed by the practice of HMO's in our area. Patients do not get the care or the attention that they are promised or even the care that they deserve. There is a lack of personal attention as demonstrated by previous discussions, and also by our own emergency room reports which are as follows:

First, there are long waits to get approval from HMO medical directors for treatment and or admission.

Second, HMO doctors seemingly are never available to the emergency room patient, and as the result, hospital emergency rooms, or staff physicians on call, must assume the care and the legal responsibility for the patient.

Third, repeated incidents where patients have been dropped from HMO programs because of expensive chronic illnesses, long hospitalizations or when longstanding office care is necessary.

Fourth, avoiding tests or treatment that could be lifesaving is a common practice of HMO's for financial incentives.

Fifth, nonphysician care is rendered in some instances, where MD's or DO's should actually be present at the time of diagnosis or treatment.

Where does this impersonal, restricted, uncaring profit-motivated system end? In some cases, it is medically unethical and unprofessional.

Fifth, organized medicine. The AMA, the Florida Medical Association and its constituent county societies are concerned about health care costs and the presence of avante-garde approaches including the HMO's. We find no unique ethical issue in arrangements——

Mr. MICA. Summarize; 30 seconds.

Dr. SAYFIE. OK.

I will just say that if a doctor accepts compensation for economizing on patient care, this constitutes a conflicting interest. If HMO's are to continue to exist as is, giving less than quality care and advertising with Government sponsorship, I feel greater problems in professional liability will develop.

If HMO's are to succeed, they must improve their primary care personnel and respond to the everyday, routine needs of the American people, which are used to getting more than HMO's are giving.

The eyeglasses, hearing aids, et cetera, are carrots used in advertising to get subscribers to join a health-care system which is at best generic and gives less to people who deserve more.

Gentlemen, you and your Committee on Aging must decide which road to take. Decreased quality of care; decreased costs, or both, or a compromise. You must decide what Americans deserve.

May God help you with your decisionmaking.

Mr. MICA. Thank you.

[The prepared statement of Dr. Ernest G. Sayfie follows:]

PREPARED STATEMENT OF ERNEST G. SAYFIE, M.D., PAST PRESIDENT, BROWARD COUNTY MEDICAL SOCIETY

Honorable Congressmen of the United States House of Representatives, designated guests, my colleagues and friends.

It is difficult to describe a general perspective of HMO's today in five minutes. It is more difficult to understand the multitude of forces that focus on and have an effect upon HMO's and other health care delivery systems that are developing in America today. Therefore, today I have chosen to outline some of the problems and effects of health care and how HMO's fit into that scenario.

FACTS OR PREMISES

1. Health care costs are HIGH! INFLATION, TECHNOLOGY, and PROFESSIONAL LIABILITY PROBLEMS are the majority of reasons for this. Also attributed to this is an increase in the number of physicians—21% are foreign medical graduates.

2. Government, industry, and the people of this Country cannot deal with the increased indices of health care costs.

3. Organized medicine is having difficulty in dealing with or solving the problems of increased health care costs.

ACTIONS OR REACTIONS TO THE ABOVE FACTS

1. Prospective Payment Systems have been formed both by government and industry.

2. Government has developed DRG's (which stands for Diagnostic Related Groups), and PRO's (which stands for Peer Review Organizations) to control the utilization of health care. The Government also has supported HMO's (which stands for Health Maintenance Organizations).

3. Health Care Coalitions have been formed to produce PPO's (which stands for Preferred Provider Organizations).

4. Entrepreneurs have formed HMO's.

5. Organized medicine has chosen to freeze fees and wishes to be the patient advocate with a high quality of care being delivered to patients at reasonable costs.

RESULTS

1. Prospective Payment Systems—generally guarantee care at a fixed rate but quality of care is overlooked and not guaranteed.

2. Government—has a financial fiscal problem and a fiduciary problem. The government is running out of money to render care of any quality to the people for whom it has a fiduciary responsibility, and it is searching for systems and hoping that the PPS's, DRG's, and PRO's will help. Demonstration HMO's have been established as a means to possibly reduce costs.

3. Health Action Coalitions—The Chief Executive Officers of leading corporations have thrust themselves into the area of health care costs and formed HAC's in order to understand why health care costs are rising. They do not know what to do, but they are looking. They have decided to become more involved in the governing bodies of hospitals in order to help control the costs, because approximately 65–70% of health care costs are at the hospital level where the doctors write orders for 75–80% of these costs. the PPO's were formed to guarantee discounts on health care delivery, with high quality and efficiently run hospitals and medical staffs. Thus far, the viability of this approach has not been validated by any credible source.

4. HMO's—Because of government interest in financial aid and financial sponsorship, astute businessmen, whose motivation is bottom-line profit, devised a method whereby a "generic" health insurance policy for industry and private citizens, including Medicare participants, could be delivered. I call this "generic" because patients do not have their usual free choice of medical practitioners, and medical facilities, and they loose the ability to get a unbiased second opinion. Remember this is America and not England! We in Broward Country, both hospital providers and physician providers, who have tried to cooperate with the HMO's, are disappointed, discouraged, and dismayed by the practice of HMO's in our area. Patients do not get the care or the attention that they are promised or even the care that they deserve. There is a lack of personal attention as demonstrated by emergency room reports as follows:

(a) Long waits to get approval from HMO Medical Directors for treatment and or admission.

(b) HMO doctors not available and as a result hospital emergency room or staff physicians on-call must assume the care and the legal responsibility for the patient.

(c) Repeated incidents where patients have been dropped from HMO programs because of expensive chronic illnesses, long hospitalizations of when long-standing office care is necessary.

(d) Avoiding tests or treatment that could be life-saving is common practice of HMO's for financial incentives.

(e) Non-physician care is rendered in some instances where MD's or DO's should be present at the time of diagnosis or treatment.

Where does this impersonal, restricted, uncaring profit-motivated system end? In some cases it is medically unethical and unprofessional.

(5) Organized medicine—the AMA, the FMA and its constituent county societies are concerned about health care costs and the presence of avante-garde approaches including the HMO's. We find no unique ethical issue in arrangement which seek to provide quality medical care by containing costs. We do not believe that a physician should be rewarded by payments for not providing or prescribing treatment or hospitalization. We do not feel that a physician should be financially penalized because of necessary hospitalization costs which are incurred on behalf of patients that may exceed DRG rates. We feel physicians are entitled to compensation commensurate with the value of services they render. If a doctor accepts compensation for economizing on patient care, this constitutes a conflicting interest. Prospective limited reimbursement is a threat to quality care. Financial incentives and penalties geared solely to costs intensify the threat to quality care. It is unethical for a physician to profit for not providing or prescribing necessary services or facilities.

CONCLUSIONS

If HMO's are to continue to exist as is, giving less than quality care and advertising with government sponsorship, I feel greater problems in professional liability will develop. If it is the government's intent to mislead the people of this beautiful

land, then continue to support the HMO's of today. If you wish to refine and fine-tune the health care system, I suggest that you work with the AMA and the state medical organizations in a forum where the government and the gold standard-bearer of health care delivery in the world, the AMA doctors work together trying to solve the problems of health care delivery in America. TODAY'S HMO IS NOT THE ANSWER.

If HMO's are to succeed, they must improve their primary care personnel and respond to the everyday, routine needs of the American people, which are used to getting more than HMO's are giving. Forget the eyeglasses, hearing aids, etc., which are carrots used in advertising to get subscribers to join a health-care system which is at best "generic" and give less to people who deserve more.

Refer to Interim Report—February, 1984—Health Policy Agenda for the American People.

Mr. MICA. My next witness, formal witness is Dr. Lee Fischer, president of the Palm Beach County Medical Society. Welcome, Dr. Fischer, please proceed.

STATEMENT OF DR. LEE FISCHER

Dr. FISCHER. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, thank you for the opportunity to present our concerns about apparent difficulties patients are experiencing in Palm Beach County with the medicare health maintenance organizations, HMO's, Federal demonstration projects. I am Dr. Lee Fischer, president of the Palm Beach County Medical Society, and a practicing family physician in West Palm Beach, FL. Our society represents over 1,000 physicians in Palm Beach County. We are a component member of the Florida Medical Association.

In order to facilitate my testimony and confine my statement to 5-minute limit, I will briefly describe the categories of concerns. I have furnished you and the other committee members with copies of this statement and documentation for each category. In the question period I will be glad to elaborate or further define specific complaints in any category and the documentation supplied may assist you in your questioning. The medical society would also like to use this opportunity to suggest improvements in this medical care delivery system.

The categories of concerns are: Enrollment practices, disenrollment practices, quality of care, continuity of care, and resolution of patient concerns.

Enrollment practices: In order to enroll medicare recipients, the IMC HMO has advertised heavily, a standard practice. However, it has been brought to our attention that some persons who merely requested further information have been enrolled without their knowledge. Persons have been enrolled without any explanation about where to present themselves for treatment, and most distressing, that senile persons with little or no familiarity with the English language and who reside in a rest home have been enrolled. Documentation about these and other apparent enrollment abuses are in your packet entitled, "Enrollment Practices."

Disenrollment practices: A significant number of the medicare HMO patients have complained to their former physicians about their difficulties in disenrolling. We have received documentation from persons who call the HMO provider and are told they are disenrolled without being informed that a specific disenrollment form must be completed. Others who have completed the form, believe

they are back on regular medicare, and discover following treatment that they are still carried on the HMO rolls in Washington. This has resulted in grave financial difficulties for some Palm Beach County senior citizens, as you will note in the documentation entitled, "Disenrollment Practices."

Quality of care: Senior citizens have written and called the Palm Beach County Medical Society for advice and assistance concerning their care within the HMO system. Some of those who have contacted us do not know to what physician or center they have been assigned, what qualifications their HMO physicians have, and report having extreme difficulty in arranging appointments, particularly with specialists. Reports we have received also indicate that some HMO's would appear to be ineffectively exercising quality of care supervision over the operations of their franchisees. In the documentation entitled, "Quality of Care," we have included reports of some extremely serious difficulties senior citizens have encountered that would seem to demonstrate a lack of concern for their medical welfare.

Continuity of care: Apparently, few of the HMO physicians have hospital privileges, leaving the admission and hospital care of patients up to non-HMO physicians who are on duty when the patient presents himself at the emergency room. Private physicians have reported that they have not been contacted for information about the condition or prescribed medications and treatment of former patients who have joined an HMO. We have also received a report, included in the documentation, entitled, "Continuity of Care," concerning an HMO enrollee who had been seen by her HMO physician and had her records forwarded to the HMO. This patient died, although her former private physician undertook her care when the HMO refused to accept responsibility for her care. Apparently, some of the HMO physicians are seasonal residents who have now returned north, opening other concerns about continuity of care.

Resolution of patient concerns: Many senior citizens who have enrolled, whether knowingly or unknowingly, in an HMO are in a dilemma about where to turn for assistance in resolving their concerns. Patients report notifying the HMO with no results, writing or calling officials in Tallahassee or Washington, and still are unable to achieve results. In the packet of documentation entitled, "Resolution of Patient Concerns," you will find a number of examples of the difficulties senior citizens are experiencing.

The physicians of the Palm Beach County Medical Society are extremely concerned about medical care provided to senior citizens. An accepted standard of care across the United States of America is the doctrine of informed consent. This means that it is vital that any patient understand all of the ramifications of treatment, or possibly nontreatment, of whatever condition exists. I submit that informed consent is absent for many HMO enrollees, in each area I have highlighted, and that this situation must be rectified. Additionally, continuity of care is a prerequisite for quality medical care, especially when dealing with elderly patients who may have chronic illnesses.

Since we are concerned about the rising cost of medicare, as is every thinking citizen, we respectfully offer the following suggestions to improve the HMO concept of medical care for the elderly.

Since individual HMO's have the opportunity to benefit financially by enrolling the highest possible number of medicare beneficiaries, regardless of the quality or availability of optimal care, and without the informed consent of enrollees, we suggest that potential HMO members enroll and disenroll from this system through their local Social Security office. This would allow an unbiased representative the opportunity to explain the advantages and disadvantages of this health care delivery system, and assign the enrollee to the HMO center most convenient to the enrollee without any financial incentive being present. While we understand that this might result in a need for additional staff in the Social Security office, we believe that informed consent and the avoidance of any appearance of overriding financial incentives well worth the Government's support. Additionally, the medicare system may benefit when fewer patients disenroll, only to proceed in procuring private medical care for those conditions which were not addressed during their HMO membership, and during which time the Government was paying 95 percent of their expected medical costs.

In order to best ensure both continuity of care and quality of care, some system of peer review and franchisee control must be required of the primary HMO contractors. Some requirements must be enacted to require HMO physicians to refer members to facilities where their physicians are able to provide both emergency and continuing care. A patient's care, and his potential for complete recovery, is severely compromised when the physician on call in an emergency room must accept responsibility for the admission and hospital-based treatment of the presenting patient, with no foreknowledge of the patient and when no followup is possible.

At either the State or Federal level, possibly both, there must be a designated office to receive and resolve patient concerns. We suggest that, upon enrollment, each enrollee be given written instructions on how and where to report potential difficulties.

Again, thank you for the opportunity to voice the concerns of the Palm Beach County Medical Society about the local HMO demonstration projects to deliver health care to medicare recipients at a lower cost to the Federal Government.

Please look through the documentation I have provided on each of the concerns we have raised. I will be glad to answer any questions or provide whatever further information you may require.

Mr. MICA. Thank you.

I would like to make an observation, and I think this is important. We have had a lot of problems highlighted about HMO's, but if I am correct, and any of the panel please tell me if I am not, no one has said that we should do away with HMO's, or there is a problem with the concept of HMO's.

What we are talking about, and I am very pleased to hear this even from people who have real concerns about HMO's, are recommendations, constructive criticism, and ways to correct problems that have come to our attention in HMO's.

Outside of the fact that Mr. Fowler may not have had the information that we, the committee, will need and have to seek in the future, I think we have gotten more from the public and the providers here than we have in any of our Washington meetings. So, it has been helpful.

With that, let me proceed. Let me ask a couple quick questions. Mr. Fowler, what is the percentage that you are shooting for in HMO's—nonmedicare versus medicare and medicaid. I understand there's a regulation. Can you just take the microphone, because I would like to ask these individuals what the percentages are in the marketing program.

Mr. FOWLER. Under the demonstrations, the HMO's have been permitted to enroll up to 75 percent medicare/medicaid enrollees and have a private enrollment of 25 percent. The TEFRA law, the new law that we are going to be implementing, requires a 50-percent mix between private and medicare/medicaid enrollment.

Mr. MICA. When do they have to meet the 50 percent deadline?

Mr. FOWLER. The law is written so that it is on the day that they first contract with us.

Mr. MICA. How about the existing ones?

Mr. FOWLER. Well, when we convert the existing ones to TEFRA, they will have to meet that requirement and this is going to present a problem for one or two HMO's; one of them is here in this area and another one is in California, that I'm immediately aware of, that have more than 50 percent medicare enrollees.

Mr. MICA. We have representatives from two different HMO's at the table.

Could I ask you your percentage of Government medicare/medicaid versus private?

Mr. ROSE. I can't give you exact figures on that, but I can tell you at AvMed, our business is predicated on what our private business is, including PPO's. Our medicare business is not an overwhelming business by any stretch of the imagination. In terms of percentage, I do not have it available.

Mr. MICA. Do you foresee any problem in meeting Government requirements to have a balance of non-medicare versus medicare/medicaid?

Mr. ROSE. No, as a matter of fact, we favor that. The mix is essential to us, also.

Mr. MICA. Dr. Sanders?

Dr. SANDERS. Yes, that's exactly our objective also. We are within at the present time, I believe a 60/40 mix, in terms of medicare versus commercial.

Mr. MICA. You have 60 percent medicare, 40 percent commercial?

Dr. SANDERS. I believe those are our current figures, but I would like to have that updated to get a specific figure.

Mr. MICA. Do you offer freebies for the commercial part?

Dr. SANDERS. Do we offer freebies for the commercial part?

Mr. MICA. Free glasses——

Dr. SANDERS. I don't believe we do.

Mr. MICA. You do not.

Dr. SANDERS. I don't believe we do, but I would——

Mr. MICA. Do you charge the same rates for commercial versus Government?

Dr. SANDERS. The rates are totally different. The rates are predominantly set in terms of the medicare situation by what the adjusted per capita rate is established by the Government for each medicare patient.

The commercial rate is similar to what the market bears in terms of all other HMO's that are providing a commercial plan.

Mr. MICA. Are the rates higher for the commercial, than the Government on the average?

Dr. SANDERS. No, they're not.

Mr. MICA. They are lower?

Dr. SANDERS. They're lower.

Mr. MICA. I'm sorry, Dr. Sayfie, did you have a comment?

Dr. SAYFIE. Yes, I think that it should be pointed out what the rates are for medicare, what they are for nonmedicare, and what they are for children under age 10.

I think you will find there is a significant difference.

Mr. MICA. I don't know. I'm probing.

Dr. SAYFIE. It's my understanding, at least one HMO that I'm familiar with which was offered to me which I refused, for children under age 10, you'll give $5 per month for a patient from the roster.

For persons from 10 to 65, you will get $7.18 per month per patient on the roster.

For medicare patients, you will get approximately $15 or $18 per month, so medicare is paying twice as much as other people.

Dr. SANDERS. May I make one other comment?

I think relative to the question, we need to keep something in perspective, the perspective is that the medicare age patient population requires more services on the average than the nonmedicare aged patient. This has been identified throughout the country.

As a matter of fact, one of the largest HMO's in this country in the past, stayed very far away from trying to market to a medicare age patient population because of the fact that the health care requirements that were necessary for that age population were so much higher, and probably could not be met that economically by the commercial cost.

Mr. MICA. Just to pick up on a point from Dr. Fischer, he indicated that, and this has been a thread throughout these hearings, that enrolling and disenrolling is a major problem, or has been a major problem. I gather that would be termed an administrative problem, and not a medical problem unless you have a medical emergency during this period, then it would be very difficult.

But he talked about, maybe you could expand on this, Social Security office, or some other office allowing or handling the enrolling or disenrolling procedures.

Could you tell us your ideas on that and then I would like to have a comment on it.

Dr. FISCHER. Well, what I said in the testimony is that there is a financial incentive to enroll as many people as possible. After all, the HMO's are getting paid in Palm Beach County, something like $181 per month for everybody that can enroll. So, the bonus is for

them if they can enroll 100,000 people in Palm Beach County, they're going to make a lot of money.

Now, you've got to figure out a way to deliver medical care to those people. The Government in the proposed regulations you keep referring to with Mr. Fowler, has tossed out the idea in the proposed regulations of perhaps having an open enrollment period, and if there's more than one HMO in an area, then having a coordinated enrollment period, so they'd all have to enroll at the same time, which might foster competition, which I think is an excellent idea.

I'd also like to point out that we've been going under the asumption that medicare's going to save tons of money. In the proposed regulations, they say, based on these assumptions, we estimate that net medicare program costs would increase by $30 million in fiscal year 1985, and $65 million in fiscal year 1986, as a result of implementing these HMO proposals.

They also say, of course the actual resulting costs could be higher than the estimates if persistent adverse selection in the type of people they were enrolling were to occur.

In other words, if they enrolled a bunch of healthy people, medicare could cost a lot more. That's in the proposed regulations; I'm not making this up as you well know.

Mr. MICA. Mr. Fowler, Mr. Doherty, and then Mr. Sanders and Mr. Colavecchio.

Mr. FOWLER. We estimate a slight increase in costs under the new regulations, that is, because in our existing contracts, there are 900,000 people enrolled nationally in the prepaid plans.

Many of those are under cost contracts, so that if all the cost contracts were eligible and ready to convert to risk reimbursement, initially there would be some additional first-year costs; and that's what those figures represent, the first 2 years, I believe.

After that, the costs should go down, but there would be a one time conversion cost because of converting people from existing cost contracts to 95 percent reimbursement.

On the other point, to coordinate an open enrollment, last week, I believe the Conference Committee did adopt an amendment to the medicare law to provide for coordinated open enrollment, and I don't know if the President signed that legislation yet, but it's in the reconciliation bill, and that did pass.

Mr. MICA. Would you comment; have you given any thought to third party handling, such as the Government, handling the enrollment and disenrollment?

Mr. FOWLER. No, sir, we have not considered that seriously, but we're doing a number of other things to get at this problem.

I think the answer is to improve the performance of my office and the HMO's in this regard. One of the things that we're doing is installing a new data processing system that will permit the HMO's to have instant access here in Florida on a trial basis to information in our files so that people won't be told one thing by an HMO and a second thing by my office because the records are out of sync, if you will.

Also, we've asked the HMO's to institute a new procedure that will permit a person who wishes to disenroll, to disenroll as quickly as the next day, if they come in on the 30th day of the month, and,

to permit them to be disenrolled on the first day of the next month routinely.

I think this will go a long way to improving the performance in that area. I might point out, though, that while we can do this in demonstrations, the TEFRA law itself requires that when an individual disenrolls, he give the HMO and the Government notice that amounts to a minimum of 30 days, and can work out to be 60 days, because the language of the law says that disenrollment is effective the first day of the month following the first full month that the disenrollment request is made.

Mr. SMITH. It was received after the 15th of the month.

I believe with most of the HMO's that are involved, a disenrollment received by them prior to the 15th, is supposed to take effect the first day the following month, because after the 15th, it's the first day of the month following the following month.

Mr. FOWLER. Up until this month, it is true, it has taken 4 to 6 weeks for someone to disenroll from an HMO. We changed the procedures this month for the demonstrations to shorten that time period to as little as one day.

But, the new TEFRA law, I think, even extends the period rather than reducing it.

Mr. MICA. Mr. Doherty.

Mr. DOHERTY. I just wanted to follow through on a comment by Dr. Fischer. You see the idea behind this law is that the elderly are supposed to get the full benefit of the taxes that they pay into the medicare system. As it is now, HMO's throughout the country are treating the elderly for roughly 80 to 85 percent of what it is now costing the medicare system for the fee-for-service population that Dr. Fischer serves so well.

So, the notion is that the Government, by prepaying the HMO, will save 5 percent off the top, as an incentive to get the Government into the program. Then the HMO will receive 95 percent, with as I indicated, the difference between the HMO's cost for the care and the 95 percent going to the elderly.

I think that it's a little bit misleading to talk about these additional services as free services. Those are services that the elderly earn as a matter of right.

All the HMO provision tries to do is to put some equity into the system for the general public, for the Government and for HMO. So these are not free services; I just want to make that clear.

Mr. MICA. Dr. Sanders.

Dr. SANDERS. Yes, I just want to underline one of his statements, made by Mr. Fowler, and that is, IMC at the present time has a contract with Compu Serv so that we, literally, within a few minutes will bypass all of the problems that we had in the past, in terms of enrollment, and will have direct access through the Social Security Administration computers and be able to verify instantaneously the status of the individual in terms of enrollment.

Now, let me make a comment about disenrollment, because one of the witnesses commented about the fact that patients who had excessive medical needs, or have chronic diseases are being forced to disenroll.

That is categorically incorrect, but I want to point out where that administratively can be a problem in disenrollment. This was

a suggestion made to us by HFCA, they said, "Look, we have to make 100 percent sure that your patient, who has an illness, who is disenrolling, is not disenrolling because someone in your organization has tried to do that."

So, we make every effort to do a complete exit interview with the individual to make 100 percent sure that it is their voluntary will to leave as opposed to some outside force that is causing them to do that.

Mr. MICA. Well now, I recognize, and in fact, maybe I ought to stop and ask consent from my colleagues to get an answer to this question, if you don't mind, without objection.

What about the suggestion, then, that third party do the enrolling and disenrolling?

Dr. SANDERS. I don't have any problem with that. I think you're going to have a cumbersome type of situation.

I think the critical thing is whether or not enrollment and disinrollment is occurring appropriately. I think that's the basic issue, and I think what is happening after all the comments made from Mr. Fowler and myself, that is now being addressed, and being addressed very carefully and very quickly.

Mr. MICA. Mr. Colavecchio.

Mr. COLAVECCHIO. Just a couple comments, if I may.

As far as the comments Mr. Fowler made, we are installing two computer terminals this week in our Patient Service Center so we do have direct access to the computers in Baltimore, so we'll be able to know instantaneously where they stand in the system.

Another thing we're talking about. We're talking about 95 percent of reimbursement. I think that figure is erroneous when you look at it. First of all, you're saving 5 percent from last year's cost of medicine. To that, you must add the amount of money that has been spent to pay Blue Cross and all of the other carriers in order to process the payment.

For instance, this State alone, $50 million is paid to Florida Blue Cross just to process the claims, and the other thing is that the cost of living of medicine has not been figured into that.

So when you look at the cost of savings through the Government, you're not looking at 5 percent, you're looking at closer to maybe 15 percent.

A comment about, Dr. Fischer made a comment about followup care. In our offices, every patient of ours is discharged from the hospital, receives a telephone call the day they're discharged. They're either set up for home care or to have a visit in our office within a week to 10 days, so that we can evaluate their situation.

Now, with all our own specialists and admitting physicians with the notes coming in on a daily basis, we have a complete overall picture of that patient.

Last, no one's ever been denied care in this system because they're sick. I think that's an erroneous statement by anyone who makes that, because we are not in any way allowed to take and refuse a patient. We have patients that are almost on their deathbed, and we must accept them.

I think if you would take the time to come to our office and see, and question our patients, you would find that is the case.

Mr. MICA. Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. Doherty, I certainly do appreciate your springing to the defense of Mr. Fowler.

I was not attacking Mr. Fowler personally; it's just that frankly, I think HFCA, to some degree, has been overwhelmed with the work that needed to be done in terms of this demonstration project, and I don't think they were prepared for it.

Mr. Fowler, I looked through your statement, and there aren't any statistics in there at all other than the amount of people that are enrolled in the process, how many HMO's are in the process, how many people are enrolled, et cetera.

That's not the kind of statistics I was looking for.

For instance, what statistics are there from HFCA which give us an idea of how many per patient visits or how many patient visits in total there are for the medicare beneficiaries that are enrolled in the HMO's as they were for these same comparable numbers of patients, not the individuals themselves when they were not enrolled in the HMO system. Is there greater utilization or less utilization? If there's greater utilization, how much would we then be saving by having them making more visits to HMO's, but not having to pay out any more money because they're already capitated at a certain amount? There's nothing in there about that.

How does any of this cross referencing take place, in the sense that now when we look to expand the projects, nationwide, are we going to assume that what we want to happen will happen if we don't have the statistics from the demonstration project.

Mr. FOWLER. Yes, sir. We have in my office statistics such as those you're asking about since 1972, I guess, for all HMO's.

Mr. SMITH. I'm talking mainly about HMO's in the demonstration now, because when you open it up nationwide, you're opening up HMO's.

What happened to medicare beneficiaries?

Mr. FOWLER. HMO's that have medicare contracts?

Mr. SMITH. That's correct.

Mr. FOWLER. There are 91 plans. What I was trying to say is I do not, at this point, have the detailed analysis for these five demonstrations here in Florida, but we do have statistics for most of the 91 contracts going back several years, and what they show generally—and they vary from one HMO to the next—is that hospital days per thousand for medicare people in an HMO are something like 2,000 days per thousand in that range.

In the fee-for-service system, the days per thousand are, maybe 3,600–3,800 days per thousand.

Mr. SMITH. That's almost half of the hospital days for HMO patients as it is for fee-for-service patients. To what do you ascribe that? On what basis, now, do you find that that's taking place? There must be some correlation between the statistic and some medical reason, or administrative reason, or whatever else?

Mr. FOWLER. Some studies have suggested it's a matter in part, of the self-selection on the part of the people that choose to join the HMO.

A more recent study on a younger population by Rand Corp. tends to refute that and ascribe those kinds of utilization reductions to the medical management of the patients by the HMO.

Mr. SMITH. Mr. Rose's wellness concept, for instance?

Mr. FOWLER. It's attributed to the judicial management of health promoting and delivering services in an ambulatory setting rather than in an institutional setting.

Mr. MICA. Thank you.

Dr. Sanders?

Dr. SANDERS. Congressman Smith, through the Government DRG Program, I guess which has been in place for approximately——

Mr. SMITH. Nine months.

Dr. SANDERS [continuing]. Nine months, you already have significant evidence of dramatic reduction in the hospitalization rate. The DRG system is, in essence is very similar to what the HMO's philosophy has been since 1929. I want to underline, again, that the reduction in hospital use does not equate with the reduction in medical care.

All of the studies that have been done have significantly demonstrated that there is no reduction in care.

You have to also look at what the motivation in the past was for hospitalizing a patient. If you had private insurance, most of the testing that was done, that could have been done on an ambulatory basis was not covered by your private insurance, if it was done on an ambulatory basis.

So, there tended to be a pressure to hospitalize that patient and get those diagnostic procedures done within a hospital setting where they were covered by your insurance.

We emphasize ambulatory care, and that's where the saving occurs.

Mr. SMITH. Let me ask you, Mr. Colavecchio, you submitted all these cards. I pulled out the ones from the not satisfied pile.

Generally these cards tend to support most of what we believe are the major problems with the running of the program, in general. That is, "That it takes hours to make appointments by phone;" "Did not see Dr. So and So;" "For senior citizens who have any problems, they would like more than one experienced doctor;" "My first experience with the senior plan is very satisfactory; but my second visit with the female doctor left us with a bit to be desired." "Why no opthamologists—" "Phone for appointment is difficult," "Don't tell you results of tests," "Expect this plan to work better with time." "Too long to wait for appointments, too long to wait to get results from x rays, too long to wait in the waiting room to get an appointment."

You've been in the program how long with IMC?

Mr. COLAVECCHIO. We've been in since January, sir, 6 months.

Mr. SMITH. All right.

And were you providing medicare services prior to that time?

Mr. COLAVOCCHIO. Yes, sir, we had what is called the health care prepayment plan. It was a new program under HFCA that provided all part B services to our patients.

Mr. SMITH. Based on that, do you find that these complaints are the same things that were prevalent previously?

Mr. COLAVECCHIO. Well, first of all, those are the minority of those 3,000.

Mr. SMITH. I understand, but I gravitated to that pile.

Mr. COLAVECCHIO. Let me say how we have addressed this.

In the beginning, when you had 10,000 or 12,000 patients, everyone wants to be the first one in the door. We have gone ahead and we have hired six new physicians; we have turned——

Mr. SMITH. I don't want to get into the specifics on what you've done.

Mr. COLAVECCHIO. We've addressed the problems that were inherent in the program in the beginning of the program to a point where we've installed 65 telephones so our patients no longer have to wait on the telephone.

When you're receiving 2,000 phone calls a day, you have to have a good telephone system.

Mr. SMITH. When did you do that? The one that says, "Too long to wait, too long to wait to get results, too long to wait in the waiting room," is May 18.

When did you put that system in?

Mr. COLAVECCHIO. We opened our patient service center about 2 weeks ago. We have addressed those problems.

We know what those problems were and we took action.

May I make a statement if I may?

The gentleman who was in the previous panel, discussing the lady that had the problem with the hospitalization. This is not a problem that is inherent to HMO's. This is a problem that is medicare oriented.

Mr. MICA. Could you describe it again. Is this a problem with custodial care?

Mr. COLAVECCHIO. Yes; this is a problem with custodial care, Congressman Mica.

Under medicare, a patient, and I think Henry Brown sitting over there, and he's the chief financial officer for St. Mary's, will verify this, under medicare, and I feel this is a shame, a patient who needs custodial care, where nothing else can be done for that patient, is made to go home. Otherwise, the patients must pay the bill themselves. This is inherent in the medicare program itself.

This person is not the only person that has this problem. There are hundreds and thousands upon thousands of people in this country who face that, so it's not a problem just inherent in HMO, sir, it's a program problem of medicare itself.

Mr. MICA. Just on this point. As I understand it, that's correct in HMO's and medicare, but I would also just add, and staff correct me if I'm wrong on this, that for a patient going to a hospice, this is not a problem.

Mr. COLAVECCHIO. This particular patient was our patient. I'm very familiar with the case. The patient was sent home. The hospital, itself, said it was custodial care. We sent the patient home. We sent our home care unit in; we called hospice to come in the next day. This gentleman saw the problems inherent in this situation with a 94-year-old man trying to take care of his wife.

So, we, immediately upon hearing about it from your office, put the patient back in the hospital to decide what we could do.

We brought HRS in. They did not qualify for medicaid. They had money, but they did not want to spend the money to put the patient in a nursing home.

Mr. CUSTAGE. Not true, sir.

Mr. COLAVECCHIO. We have it documented. This is the problem, not only this lady faces, but many, many thousands upon thousands of people face in this country.

They're forced to use all of their money, until they reach a poverty level of, maybe $1,800, and they're accepted into the medicaid program. Ironically, they receive the same care as if they were in the medicaid.

Mr. SMITH. Let me ask of the doctors.

Many of your colleagues are beginning to enroll as part of the medical provider services, in the teams, in HMO's. Many of them are members of the Broward and the Palm Beach Medical Society.

You don't castigate these members for any reason, I mean, many of these are your colleagues and friends. Don't you feel it's important that if they're going to be doctors, that they should be members of the Palm Beach Medical Society and the Broward County Medical Society, et cetera.

You mentioned doctors who are out 3 months, nonresident doctors who go back up, wouldn't you prefer to see these kinds of doctors, your peers, your colleagues involved with people who are FACB, and belong to other very prestigious medical organizations, as a showing that they achieved a high level of medical proficiency?

Dr. SAYFIE. Yes, Mr. Smith, we would.

We would like to have every physician who practices in the field a member of organized medicine, because, unfortunately, that isn't so. There's no way legally we can force it. We only invite them to join in order to have a body dedicated to the welfare of the community.

We really havo no big problem with combining quality care with decreased costs.

We're just concerned, quite frankly, about the problems which occurred heretofore, about the lack of care.

The problem really is the primary care. It's the person getting a proper physician who can actually have some empathy or at least some sympathy for the patient to take care of his problems and follow through.

Our experience, and as chief of the hospital at this time, our biggest complaints, really, are through the emergency room, where we can't get the assigned HMO doctor. It would take 4 to 8 hours, many times, for a fractured hip, and I experienced this problem myself with an 88-year-old former patient of mine who decided, through her condominium, to go to an HMO. We couldn't get the HMO group; we eventually went ahead with the surgery without endorsement, and eventually, because the family threatened to sue the HMO, they finally paid some 7 or 8 months later for the cost.

Now, the problem, again, is not with the specialist, because the specialist did really work very easily with the HMO's. The problem is in the primary care, which means the initial encounter. That's the problem that we seek, and that's the problem that we'd like to correct.

Mr. SMITH. On the problems that you're detailing, the problems referred to today, are to some degree, problems that were inherent in the system that started and got a large amount of enrollees. In fact, these problems may not be as this situation becomes more of

an accepted reality, becomes more of an important part in any given community, where more of your own peers, your own friends, fellow physicians, members of the various local county medical societies, become involved? Isn't that going to reduce the kind of problems that occur?

Dr. SAYFIE. Indeed it may, but right now it needs to be solved. We're not here to say——

Mr. SMITH. Have you seen any resolution over the last year or so when these HMO's really began to take hold, in Dade, Broward, and Palm Beach?

Haven't you seen a reduction? It seems to me we've seen somewhat of a recognition by HFCA and by the HMO's and others.

Dr. SAYFIE. All right. To be quite candid, I haven't seen that much improvement, but I want to state for the record that I'm not against the HMO concept. I think it just needs some tremendous improvement, tremendous regulation in what I see so far.

Dr. FISCHER. I agree completely with Dr. Sayfie's statement. I personally take calls for a doctor, who is a member of AvMed, and I've made rounds for him on AvMed patients.

A few of my patients have joined the HMO, have ended up in my hospital, and I've taken care of them, no problems, send bills in and hopefully get paid, et cetera.

But, that's not the key issue. Doctors and the American Medical Association do not oppose the concept of HMO's. I think the way some of these HMO's are working, and have been working is the real problem.

There's been somewhat of a resolution with some of these problems, because after the initial big advertising blitz people that were intelligent enough to find out that it wasn't right for them, specifically, all have gotten out. So, it's kind of found its own level, so I agree with you there.

Mr. SMITH. Mr. Chairman, thank you.

Just a final question, Dr. Sanders. You originally were brought in to start working on some of these major problems that IMC was having. Now, you're very well respected in the field, and I believe, that there is a very large mode of progress. Everybody's heard about the free chicken dinners.

One of your contract vendees ultimately did something that I know from the very first time we contacted your office, your office was aghast at it because you did not authorize anything like that.

But, as you have been going along further in this area, in terms of trying to overview and changing problems, have you met with a lot of success? Are you being able now to detail the problems and resolve many of these administrative problems, or are you still having difficulty in certain areas?

Dr. SANDERS. My major area is in the area of health care delivery and quality assurance. As I mentioned in my statement, and I didn't make that statement lightly, we have the only quality assurance program of the kind described in the entire country, not simply in other HMO's, but in the entire country.

We have a quality assurance program that does not exist, does not exist in the fee for service world. I would like to have one member of the Palm Beach County Medical Society or Dade County Medical Society, or Broward County Medical Society, or

anybody in the United States in the fee for service world, tell me the last time a review team came into their private office, reviewing exactly how they treated a patient by going into their charts within their private office, looked at how the nurses were treating patients, how the receptionist was treating patients; that does not exist.

It exists within a hospital setting, but that type of review does not occur within the private sector. It does occur in IMC HMO.

Also, let me make a comment about the physician, and whether or not he belongs to a county medical society.

The quality of a physician is dependent upon the quality of the physician, not whether or not he belongs to one society or another. When I had lectured at Hollywood Memorial Hospital, I was not a member, and I lectured to Dr. Sayfie, I was not a member of the——

Mr. SMITH. You mean in the generic sense. You lectured directly to Dr. Sayfie.

Dr. SANDERS. In continuing medical education for an audience; I was not a member of the Dade County Medical Society. I joined the Dade County Medical Society a year ago. That didn't make me any better or any worse a physician or lecturer. The quality of a physician is based upon the quality of the individual, and if we find a physician within the HMO who we feel does not meet our standards, we ask that individual to leave. Now, where is that physician? We don't take his license away. He's now in the fee for service world still taking care of patients.

Now, you know, I think what we are seeing here in south Florida is exactly the same thing that occurred in Kaiser Permanente, and is still occurring to Kaiser Permanente but not as frequently when it first started in Southern California. There is a tremendous opposition on the part of the fee for service physician to the establishment of HMO's, and we have had physicians within our organization, who literally have been threatened and told that if they continue to see IMC patients, they would no longer get another consult from their physician colleagues.

Unfortunately, that has happened. It is happening less, but it still occurs.

Mr. MICA. Thank you.

Congressman Rinaldo.

Mr. RINALDO. Thank you very much, Mr. Chairman.

Dr. Sayfie, Mr. Fowler said that there were 95,000 medicare beneficiaries enrolled in HMO's, yet that their rate of complaints is less than 1 percent. Now, doesn't that contradict your statement that people are not receiving the care they need? Wouldn't there be more complaints, and wouldn't the rate be higher if they weren't receiving the care that they need?

Dr. SAYFIE. Yes, sir, that statement does contradict my statement, and I think it's the fact as he mentioned, and qualified, that that's just a certain of level of complaints he gets. He doesn't get the complaints that actually go to HMO's themselves. These are the complaints that he receives in his office, which is 0.9 percent, or something to that effect. I think if you'll look at the complaints that the BCMA, or the Palm Beach Medical Association gets or the

Dade County Medical Association, we think that we are the aegis of medical care, then you'll find that number to be a lot larger.

Mr. RINALDO. Well, what are you doing to improve that? Does the Medical Society, for example, have any ongoing contacts with HMO's to help them improve their performance.

Dr. SAYFIE. We have no control, sir.

Mr. RINALDO. I'm not asking control. You're saying complaints. I'm wondering if you do anything in the interest of quality medical care for the people of this country to help them improve the quality of care.

Dr. SAYFIE. Yes, sir; we do. I think both Mr. Smith and Mr. Mica have received complaints from me as President of the Broward County Medical Association last year about complaints we have received.

We have forwarded them directly to the Congressmen in our area.

Mr. RINALDO. You have no contact with HMO's themselves, then?

Dr. SAYFIE. Not on a professional basis, not personally or as a society.

Mr. RINALDO. Yet, it seemed to me you said a few moments ago that HMO doctors can be members of medical societies.

Dr. SAYFIE. We invite them to.

Mr. RINALDO. Are they in fact?

Dr. SAYFIE. Some are indeed, especially in the specialies.

Mr. RINALDO. So, if it's a doctor, who's a specialist, who's a member of your medical society, and you receive a complaint about that doctor, then you don't do anything at all?

Dr. SAYFIE. I beg your pardon, sir, no.

We have a very, very strong censuring system that we go through, and if an individual physician is specifically complained about, then it's our responsibility to take care of that problem, but we can't involve ourselves with the HMO itself.

Mr. RINALDO. Have you censured any physicians who are members of an HMO for being derelict in their duty?

Dr. SAYFIE. I have not, or we have not, to my knowledge, sir.

Mr. RINALDO. Have you Dr. Fischer?

Dr. FISCHER. This thing has only been operating for a few months. We have very few members who are members of our medical society. No, we have not censured any.

Mr. RINALDO. Well, let me ask either of you. You've said you've had contacts with my two very fine colleagues' offices. Have you recommended to them or anybody else, legislation that you would think that would correct the problem?

Since you stated you're not opposed to the concept of HMO's, you think it's a good idea, have you recommended any legislation, anything which could cure any deficiency you feel, real or apparent, that exists?

Dr. FISCHER. I just sent 8 or 9 pages of single-spaced typed responses to the new regulations that the Health Care Financing Administration, or HHS has just proposed, yes. Those are in the mail to HFCA in comments to their proposed regulations.

Mr. Rinaldo, this document is full of complaints from patients. I think part of the problem is nobody knows where to turn.

I've got one guy calling me one time, and said, "I called the Better Business Bureau, and they said call the Palm Beach Medical Society," because he was having trouble getting payment for his HMO claim.

Who are they going to write to? Does anybody in this room know who Mr. Fowler is? Are they going to write to him?

I mean, who do you send your complaints to when you can't get a resolution? We've been referring to Congressman Mica who's done a superb job of doing something about it. No one knows who to talk to.

Mr. RINALDO. Let me just ask one followup question, then I'll be very pleased to yield to my distinguished colleague.

Do you think that HMO's can provide good care?

Dr. FISCHER. Yes.

Mr. RINALDO. Do you feel the same way, Dr. Sayfie.

Dr. SAYFIE. Yes, sir, and when you have gentlemen like our honored colleague, Dr. Jay Sanders, who is an outstanding physician, who I have a tremendous amount of esteem for many years; when you put gentlemen like him in the HMO's, you're going to have fantastic HMO's, but that time has not come.

Today's HMO is not, witi Dr. Jay Sanders, is not acceptable to medicine as it is today. We have to get more Jay Sanders involved.

Mr. RINALDO. Do you think that's because they're in their in their infancy or because they're inherently prone to problems?

Dr. SAYFIE. Because there are problems; lack of personal attention. I happen to know Dr. Sanders a long time; I can speak for him, but for the other physicians I come in contact with who are primary care physicians in the HMO systems, I am sorry to tell you that I don't really respect them that much.

Mr. RINALDO. Well, let me ask you this then: Are the medical societies encouraging the best primary care physicians to become members of an HMO?

Dr. SAYFIE. We do not encourage or discourage them.

Dr. FISCHER. We have members of the Palm Beach Medical Society actively involved in both HMO's that are represented here today. Other members are actively involved in forming independent practices associations of their own in Palm Beach County, which is an HMO; yes.

Dr. SAYFIE. If I may, one final comment.

I'd like to tell you that our hospital staff, as a staff, is looking at a concept of forming an HMO for our hospital and for our medical staff in order to provide what we think will be the best care in Broward County.

Mr. RINALDO. I think that's very commendable. My concern is, quite frankly, from the information I've received, that in my own State I haven't received many complaints regarding HMO's, and generally it seems to me that the services are rather good.

I want to make sure, and I think it's a duty of Congress to make sure, that good quality care is provided to these people, and particularly medicare beneficiaries.

So, if you're telling me that you're going to have an HMO, I say, fine, possibly form it, let's get the best people out there, let's provide the competition, and let's make sure that the American public

and particularly, our senior citizens, get the type of medical care they deserve.

Mr. MICA. With that, we will stop right here. Let me just tell the witnesses again, with this second portion of the hearing, the chairman will also leave the record open, if I or my colleagues would like to submit questions, we will have that opportunity; would like to ask you to respond in writing. To any written questions we didn't get to today, I'm going to ask you to respond as soon as possible.

So, now. All right.

We thank the panel, and this is the part where we go to the audience, and here is where we have been trying to figure out how to handle this.

Let me first ask, how many people would like to speak?

[Show of hands.]

Mr. MICA. All right. There are about 10 or 20 people. Here's how we'd like to do this.

Congressman Rinaldo has asked me to mention this again, also. If someone has already made the point that you're going to make, it is not important that you repeat it publicly. We appreciate and we understand, and we invite——

If you wish to converse, would you step into the lounge to the right, here?

We invite each and every one of you in the room to submit written statements that will be made a part of the record. We will keep the record open for seven days. You can send it at your desire to me, Congressman Rinaldo, Congressman Smith, or the Aging Committee, The Capitol, Washington, DC. We will make it a part of the record.

Here is what we have decided to do. We are going to try to get two lines over here; one line closest to the wall; the people in favor, or positive on HMO's; the other line negative, and we'll alternate for the next close to a half hour here, one minute each.

A VOICE. How about those that are in between?

Mr. MICA. In between, choose your line.

All right, we have two lines, and I'm going to ask you, just so we do this with the most appropriate speed, here's how I'd like to handle this:

I'd like to ask our minority and majority staff to each help with the lines here, and at the 1 minute mark, we'll have to gavel you down, and let me tell you, this is the normal procedure. This is the normal procedure that we abide by in the Congress. We have a 1 minute period, if you've ever seen it on TV. We have 1 minute to say whatever we like. This is in response to trying to let as many people have a little input as possible. We have gone overboard, but I will tell you now, if you speak more than a minute, or if we lose any kind of decorum here, we will have to stop the whole process.

So, let's start one at a time here, and if one of you would keep time and raise your hand a minute, I will gavel and that gavel is no reflection on the speaker, just the time.

Let's proceed. Identify yourself, if you will.

STATEMENT OF IGNACIOUS DeGUARDIA, DEERFIELD, FL

[Lines are formed.]

Mr. DEGUARDIA. My name is Ignacius DeGuardia, and I live in Deerfield. I'm reading from an article that I wrote to the Sun-Sentinel, about 6 weeks ago, "I find it very amusing for an M.D. to write against HMO's, when the fact is that it has the greed and the outrageous charges of the medical profession, HMO's would not have been in existence. It now becomes a necessity to join that organization to maintain whatever financial resources the senior citizens have accumulated in their own pockets. As one who has been dealing with the HMO, having spent a full month in the hospital, receiving the best of care, it was a pleasure and a great relief to know that there was no paperwork, no bills to pay, and I am referring to costs in the vicinity of $20,000."

Thank you.

STATEMENT OF NATALIE SELIGSON

Ms. SELIGSON. My name is Natalie Seligson, and I have a complaint to make about disenrollment.

It is almost 6 months and I have spent hours, days, running to Social Security, going all over, getting the run-around, and I finally found out that I am disenrolled on the computer of HMO, but they've never sent the disenrollment through to Social Security.

I finally contacted our Congressman Dan Mica, and he wrote me a very lovely letter, and he is working on it. He's contacted the proper agencies, and I just have to wait.

I think it is an absolute disgrace. I am not the only one. There are other people I know that are dealing with the same thing.

Mr. MICA. Thank you.

STATEMENT OF BEN STULBERGER

Mr. STULBERGER. Ben Stulberger.

My wife right now is at the HMO receiving some medical care. As a member of HMO, we who fought the Social Security in the thirties, we feel that this is something that we've been looking forward to.

That as far as Mr. Smith said, the finance plan of our country; I say the greatest problem we have is the billions and trillions that we are throwing into the space programs, and all of those that will cost over on us; the military, we should cut down on that and give us more of the benefits that we fought for through these years.

Thank you.

STATEMENT OF SHARON JOHNSON

Ms. JOHNSON. My name is Sharon Johnson, I'm the Business Manager at Fort Lauderdale Hospital. I've had numerous problems with IMC; however, I do feel that they're at a loss sometimes, too.

For instance, if I understand correctly, IMC is unable, or does not know what an individual's medicare's days actually are when they enroll someone. They have the same problem that we do, sometimes it takes 7 to 10 days in which to get a verification. So, they're at a loss when they authorize someone to our hospital for

hospital care, and then find out down the road that they don't have, like in our case, Psychiatric Facility.

Another suggestion I have would be to, perhaps, pull the providers, as far as the complaints are concerned. We got an awful lot of complaints today from the individuals, and I think that we should try to get some comments from the providers.

Mr. MICA. Thank you.

Ms. JOHNSON. Thank you.

STATEMENT OF HARRY WINNECKER, WEST BABYLON, FL

Mr. WINNICKER. Harry Winnecker, West Babylon.

I've been in the plan since it first started, and I just want to talk about the quality of the care. Well, Dr. Don Maronti, that I've had there, when he moved from West Babylon all the way to Boynton Beach, I take the 10-mile trip on account of the quality of the care.

When I left the service, I had a triglicerate of 2040. My private doctor couldn't bring it down. Dr. Don Maronti brought it down to the normal 150.

STATEMENT OF PAUL ROSS, LAUDERDALE LAKES, FL

Mr. Ross. I am Paul Ross, Lauderdale Lakes.

My mother was with a large HMO in Broward with a terminal illness. She passed away in January. We had a distressing time because we absolutely got no support. Now we're not interested in buck passing between medicare and the HMO's. When we have a terminally ill patient, we need some help, and this we failed to get. We only got it when I quickly disenrolled her, and had my own private doctor, with whom I could talk man to man, and get something done.

The terminally ill are really caught in a bind in this, and so are their families. Please do something about it.

Mr. MICA. Thank you.

STATEMENT OF JOHN MOSS, LAKE WORTH, FL

Mr. Moss. My name's John Moss of Lake Worth.

Mr. Colavecchio, seven months; I'm still not disenrolled, sir.

Congressmen, I think one suggestion I'd like to make, and I spoke to Mr. Fowler about that. We need a local oversight volunteer committee to help feed back to you what you're looking for. Think about that.

Also, I think your committee should address the cost of hospitals, now that was not addressed here, and it should be taken under consideration, because, somebody said that 75 percent of the total cost appears to be in the hospital level.

Now, cost reduction at that point is important.

Mr. MICA. Thank you, with just one comment.

We are moving into this perspective payment approach in hospitals, and the committee in other hearings is looking at a number of other health problems.

STATEMENT OF RODNEY DORSET

Mr. DORSET. My name is Rodney Dorset; I'm with Doctor's Hospital. I'm reading from a letter addressed to the Honorable Dan

Mica, dated July 6: "Dear Congressman Mica: I have previously written your office regarding my concern for HMO's, and the misappropriation of medical management decisions regarding the elderly. In a recent case that was brought to my attention is an example of what can happen when a critical, medical decision is placed in everyone's hands.

"The wife of a patient, No. 1169778, Emergency Room Record, stated to Mrs. Hayes of our Nursing Department, that she had contacted the HMO emergency clinic twice on Thursday, June 7, 1984, for an appointment for her husband, because he was experiencing pain in his chest and down both arms.

"HMO employee told the patient's wife that they would call her back, but failed to do so. The patient's wife called a second time as stated above, stressing the severity of her husband's pains."

Mr. MICA. Thank you.

STATEMENT OF RUTH COHEN, WEST PALM BEACH, FL

Ms. COHEN. Ruth Cohen, West Palm Beach.

Tied, enrolled in the Doctor's Office and very tired of waiting. Now, the president of the Palm Beach Medical Society and the other former president of the Medical Society of Broward, they both criticized the fact that in an emergency room they cannot get the HMO physician to come in and take care. They do not tell you that the hospitals will not allow the HMO physician in.

I had occasion to be brought in by ambulance, and my husband was brought in three times by ambulance. The HMO physician was allowed in only at the Humana Hospital. Doctor's Office did not allow them; therefore, the doctor on call is the one that attended to us.

Mr. MICA. Thank you.

Ms. COHEN. I have one thing I would just like to say.

May I? One point.

Mr. MICA. You better stop right there.

Ms. COHEN. I will say it quickly.

He had to be transferred from Doctor's Hospital. Doctor's Office arranged for the ambulance to take him down to Miami where you cannot get better care or consideration.

Mr. MICA. Thank you.

STATEMENT OF FERNANDO SOTO

Mr. SOTO. Fernando Soto, president of the Cuban Pharmaceutical Association.

As a Cuban, we are not against the concept of the HMO. As a pharmacist, we have a complaint about the big problem, the enroillment and disenrollment.

We think that through the Social Security, you can get statistical about that, but as a Cuban, also, I want to point out something here.

When we talk here about organized medicine and organized pharmacy, or whatever, we say that in some way that is detrimental to the profession. We don't have in the United States what we did have in Cuba, that was mandatory to belong to the professional association, what makes the profession stronger. When I heard the

comment that somebody is dismissed from a center, that person should be taking the license out of him, because that person doesn't know that in the United States, the different professions also have a presentation of the general public. I remember when I was taking my exam in New York, that one of the questions was, "To whom the board sits, and the board sits to the people."

Mr. MICA. Thank you.

STATEMENT OF MAX SUKKER

Mr. SUKKER. My name is Max Sukker, and I come from Boynton Beach.

I'd like to address the Honorable Dan Mica, and I'm very happy to meet you face to face.

I think that HMO is the best thing that happened to our senior citizens. I save $2,900 a year.

Thank you.

Mr. MICA. Thank you very much.

STATEMENT OF HARVEY COHEN

Dr. COHEN. My name is Harvey Cohen, a physician in the area, and President of the Physician's Association, which is a 175-member organization which consists of physicians in Boca Raton, Delray Beach, and Boynton Beach.

I don't want to reiterate what Dr. Fischer has said; I'll just agree with him entirely. We are in the front line receiving what you enumerated to us. We're having problems exactly with what he said, with the emergency room.

To address Mrs. Cohen, who was just up here, any hospital who will allow any physician on the staff if he's qualified to that particular hospital, and they set up their individual rules, and the people who determine that are the physicians and the organizers of the hospital.

Just one other point to make, and one that's not been addressed at in the meeting, in due deference to Dr. Sanders, all previous studies about HMO's are based upon nonprofit HMO; the originator back in 1929; Kaiser, these are all nonprofit HMO.

The profit HMO from which I had seen represents is the entirely new concept of 1980, and I think that should be addressed in new studies.

Thank you.

Mr. MICA. Thank you.

STATEMENT OF HARVEY BIRNBAUM, LAKE WORTH, FL

Mr. BIRNBAUM. My name is Harvey Birnbaum, and I'm from Lake Worth.

I'm proud to say I'm, I belong to the Doctor's Office.

I've lived in Florida 13 years and had dealings with doctors for 12½ years. I've had dealings with Frank Colavecchio's office for 6 months.

Believe me when I tell you, they are the only people I've dealt with in 13 years in Florida, you can ask other people. They are interested in you, from the nurse on. They will call you.

They will ask you. I'm surprised at night to get a phone call from the nurse there to ask how I was doing.

No doctor; I paid some pretty high prices in Hollywood, nobody in Florida has ever done that. They are terrific, and it's a godsend for Florida to have the HMO's.

Thank you.

STATEMENT OF BARBARA MULLER, TAMPA, FL

Ms. MULLER. Barbara Muller, Tampa.

I just go on the shortest line.

Just to point out that under the grant from the Health Care Financing Administration, through the American Association of Retired Persons, five cities in the country have been selected as project cities to set up an HMO informed buyer project, to let people know the pros and cons so that they can make intelligent decisions and not on an emotional basis.

One of the cities that was selected was Tampa. I happen to be the coordinator of the project. I will be calling on you gentlemen, if I may, for information, and this may be a deal where other cities should set up so the people can do it rationally, rather than done emotionally to make their choice.

Mr. MICA. Had you heard about this hearing in Tampa?

Ms. MULLER. Yes, I heard about it from our Washington contact.

Mr. MICA. Thank you.

STATEMENT OF HERBERT WARREN

Mr. WARREN. My name is Herbert Warren. I'm with the consumer council in Deerfield Beach.

I am very strongly in favor of HMO's, however, I think that one of the things that must be addressed is the matter of handling grievances. I had a very sad experience with an HMO and I disenrolled, and simply because why a utilization committee overruled the doctor for some treatment.

So, I would suggest that the HMO's have a grievance procedure where consumers and people who are not with the HMO will sit in and listen to the grievances and handle them, and give the patient the proper information and service that they require.

Mr. MICA. Thank you.

STATEMENT OF ESTHER WOLINSKY, LAKE WORTH, FL

Ms. WOLINSKY. My name is Esther Wolinsky, I'm from Lake Worth.

I've belonged to them from the very beginning of January; I've been a sick woman all my life, and I needed medical supervision for the medicine I receive.

Mr. Colavecchio's office wouldn't give me the medicine. I changed then to a senior plan, I mean their's was a senior plan.

I went later to, I forgot the name of it, anyway, it's in Lake Worth. They do not have medical centers like they're supposed to have. They have one Doctor's Office, like a general practitioner. They say they'll deliver you to places that have specialists; they don't deliver you.

I'm unable to get my eyes taken care of, and I cannot get my teeth taken care of. All the work that I need is not taken care of, and I cannot get emergency care.

Everything that they say in the pamphlet, that it's such a wonderful idea, is not being executed and nobody is answering any of the questions.

Mr. MICA. Thank you.

STATEMENT OF MINNIE FRIEDLANDER, BOCA RATON, FL

Ms. FRIEDLANDER. I am Minnie Friedlander, and I'm a citizen of Boca Raton.

I'm quite thrilled to be here today, because this is an exercise in democracy, one which we are very happy to see, and people like me, Minnie Friedlander, or you, Sam Brown can appear before a congressional committee, it is really a thrill to be here.

I have no problem with the HMO concept, but I have a problem with financial viability. These are federally subsidized demonstration programs. These are federally subsidized programs.

Mr. SMITH. That's incorrect. There are no subsidies involved with these programs.

Ms. FRIEDLANDER. Well, there's government involvement.

Mr. SMITH. Yes, ma'am, there is definitely Government involvement; there are no subsidies involved in this program.

Ms. FRIEDLANDER. I agree with you. There are Federal problems involved here. Should the Congress find it necessary to reduce, sir, let me finish.

Should the Congress in their need to balance this budget, find it necessary to change some of the formats, I won't say subsidies; I'll say Government formats; should they find it necessary to change these formats, can the HMO's survive at low cost to the people, and if the HMO's should fail, or become out of reach to the people where do we go from there?

Mr. MICA. That's why we're having this hearing.

Thank you.

STATEMENT OF ETHEL SITZMAN, BOCA RATON, FL

Ms. SITZMAN. Ethel Sitzman, Boca Raton.

I belong to the HMO since February, and I've had a broken hip on March 28. The care that I've been receiving at the medical center has been excellent, but when I was headed for treatment of my broken hip, they had no doctor to send me to, they had no hospital to send me to, so the medics brought me to Margate Hospital with their permission. However, I've had excellent care there, too. I have no quarrel with either the doctors in HMO or out of them.

But, none of my bills have been paid, and this is where I don't know who to go to.

Thank you.

Mr. MICA. Thank you.

STATEMENT OF WOODY WOOD

Mr. WOOD. I'm Woody Wood. I'm a service-connected veteran with 40 percent disability.

I've been through the mill as far as veteran's hospitals and outpatients go. I now belong to the HMO in Lake Worth, Doctor's Office.

The care there, as far as I'm concerned, is just as good, if not better than theirs, that the veterans give me.

As an example, I have a sugar problem, and I have high blood pressure. It came down when I started going to the HMO.

Thank you.

Mr. MICA. Thank you.

Mr. SLOVIN. I understand that everybody has joined the HMO's and I'd like to rise and raise an objection and propose an alternative.

The HMO's were essentially a response to the enormous cost of medical care being provided to the people. As such, they have failed in one respect. They, also, are providing medical care for a profit.

I suggest that we need a national health bill in line with the national health bills before other countries except South Africa, the Union of South Africa, and the United States.

May I draw a parallel? At the beginning of the 19th century, firefighting companies existed, that is, there were companies who went out, fought fires and got paid for them. The situation was so bad that companies, especially in Philadelphia, if you want to read the history of it, where the firefighting companies would go to work with brickbats and kill each other before they were able to fight the fire.

I suggest that the health of the American people is too important to be entrusted to private enterprise; that just as firefighting companies, just as our Armed Forces are necessary, we need them to be taken out of the domain of private profit.

Mr. MICA. Thank you.

STATEMENT OF ALBERT WHITEHALL

Mr. WHITEHALL. Mr. Chairman, my name is Albert Whitehall.

In the midfifties, I was executive director of the Blue Cross Plan in Seattle. I hope Dr. Sanders is here, because in my opinion, the HMO's were active in the State of Washington before World War I, and they were set up and operated successfully by the medical society of nearly every county in the State.

Now, this is what they do. For normal premiums, they established a pool, and out of that pool, they pay the doctors about 75 percent of their usual fees, and they pay the hospitals.

At the end of the year, they distribute what is left in the pool among the doctors. Here's what happened.

It didn't take the doctors long to see that if one of their colleagues was doing unnecessary surgery, that was money coming out of their pocket and the yearend bonus, and unnecessary hospitalization and other abuses.

Now, this is when you have doctors in control of themselves, this is the way you get medical self-discipline. That is the HMO concept.

Thank you.

Mr. MICA. Thank you.

STATEMENT OF PETE TEDESCO, BOYNTON BEACH, FL

Mr. TEDESCO. Good afternoon, my name is Pete Tedesco, I come from Boynton Beach.

I am a member of the Gold Plus Plan, Doctor's Office, under the sponsorship of Frank Colavecchio.

I'll tell you the reason why I joined Gold Plus. Mr. Colavecchio had senior plan before. His care, his interest was outstanding, better than I received, and I lived in Broward County, or way back in Nassau County.

I want to tell you; my wife, a heart condition, she's doing much better, and she has for a long time. Thank you.

Mr. MICA. Thank you.

STATEMENT OF FREDERICK FROHLICH

Mr. FROHLICH. My name is Frederick Frohlich. I am an insurance trustee for the American Association of Retired Persons.

I listened very carefully to what has been said here today. Our association agrees in concept with the concept of HMO's, but there are so many unanswered questions that, as a matter of policy, they have not made any decision.

I would like to just throw one thing out. We are talking about cost effectiveness. Is there any cap placed on these HMO's as to the amount of profit which they may retain before giving some of these profits back to the beneficiaries, namely the patient?

Mr. MICA. That is one of the things we have tried to raise in the hearings; what their profit level is, is it too much, are we paying too much.

We will be looking at that.

Thank you.

STATEMENT OF JOHN WOOD

Mr. WOOD. My name is John Wood. I am medically retired from open heart surgery three times, and if it wasn't for the Gold Plus Plan, there's no way I could afford the medicine or medication and medical assistance that I could have through the Gold Plus Plan.

Mr. MICA. Thank you very much.

STATEMENT OF ANTHONY NARDIELLO, CORAL SPRINGS, FL

Mr. NARDIELLO. I guess I'm the last one. I'm Anthony Nardiello; I'm from Coral Springs.

I was never on an HMO Plan, but my late father was on one, International Medical Centers. I just want to publicly thank Mr. Fowler, if he's still in the audience for having a portion of my father's bill paid.

The bill went on for 6 months with no resolution of IMC, from the State insurance commissioner's office, and without intervention, a lawsuit would have ensued.

I would ask the committee's permission if I could submit written material on the HMO through letters, and my personal opinion, I detest the concept of an HMO, and I consider it America's rendezvous with socialized medicine.

Thank you very much.

Mr. MICA. Thank you.

STATEMENT OF SAM SHAKSBY DELRAY BEACH, FL

Mr. SHAKSBY. My name is Sam Shaksby and I'm from Delray Beach.

I'm also a Service Officer of the Veterans. What do the Service Officers of Palm Beach County and Delray Beach demand?

I'm so glad that HMO came around. I had something to do with it for about 1½ years, and Congressman Mica knows I give him plenty of a headache.

Any service man, in the service, that goes to the VA hospital, that's nonservice connected cannot be serviced. Where are they supposed to go?

I have here in the record, there are 52,000 in south Florida that are nonservice connected getting their pension, in other words, they're getting their pension because they haven't got enough money to eat or sleep, and they hate it back in the Doctor's.

So, the HMO's, thank God, came along, and these veterans when they come to me with their medical problem, I send them to an HMO, and keep it going and get it together, please.

Mr. MICA. Thank you very much.

Let me tell you, you have been absolutely great. We really didn't know if we could work it out to give everybody who wanted to speak up there and speak, and that's just been fantastic.

Now, let me just close this, and I will call on each of my colleagues for a closing statement, and tell you that from my perspective, this has been extremely constructive.

You've given us additional meat to go back to Washington to take to our colleagues, and some of the problems and recommendations to correct deficiencies in HMO's, the enrolling and the disenrolling seem to be a key area; the financial viability, the cost and the profit; the skew of population in the HMO.

We heard some good and some bad, but I would say that on balance, the constructive comments that we've had here are some of the best that I've ever had in a public hearing.

Let me call on our ranking minority member, Congressman Rinaldo, and as I call on him, let me just thank you for coming here from New Jersey to be here for this hearing.

Thank you.

Mr. RINALDO. Thank you.

I just want to thank everyone here. It's an emotional topic; it's one that's full of controversy, so I think it's obvious from the comments that HMO's are here to stay, and I think the important thing is what we've got to do is upgrade the level of care as much as we possibly can.

I also want to point out one other thing that I particularly think is important. Your Congressman came to see me and he came to see, of course, the ranking majority member, about having this hearing. I think it belies the fact that, in many cases, you'll hear that Congress is on a recess. A recess doesn't mean that a Congressman has nothing to do. Mail keeps coming for Congressman Mica and my other colleague, Congressman Smith. The phone keeps ringing; the problems continue. But, during a recess, it really means we are not in session in Washington, and quite frankly, maybe it's a good idea to hold hearings of this type, and to get out

and meet the people and find out what the problems are, so that the proper corrective action can be taken.

Thank you.

Mr. MICA. I hesitate to do this, but I should introduce one individual I see, State Representative Carole Hanson, your Representative from Boca Raton.

I hope that doesn't start something.

Now, driving all the way up from Hollywood, FL, my colleague, Congressman Larry Smith.

Larry, thank you for being with us.

Mr. SMITH. Thank you.

I certainly appreciate the opportunity of being here, and I want to thank you for allowing me to sit in on this panel. Certainly I second your commending Congressman Rinaldo coming from New Jersey to do this.

I know he's very dedicated to finding solutions to the problems of the aging, and especially as it relates to medical care.

As I indicated before, I am very concerned about this problem, because in Broward County alone, we have about 270,000 people on Social Security. A major portion are veterans that are moving to the State, to Broward, and certainly into Palm Beach.

So, we have the same type of problems that you have here. My office receives, like your office, many of the same calls and complaints with reference to the kinds of problems that we've heard and listened to today.

We have been very concerned about the provision for the terminally ill and the custodial care. The acute emergency treatment and the problem that results when you can't find somebody to talk to, and you need somebody absolutely right that second and not even a half hour later.

The informed enrollment problem—we see that people actually do enroll without absolutely understanding what they are getting into, what they are giving up. The grievance procedure—where there are problems that need to be solved after they're in the HMO, and they don't fully understand what's available. The procedure seems to be the kind of thing that they don't want to get into because it's too much of a hassle.

But, these are not insurmountable problems. These are not problems that mean that HMO's are bad per se. These are problems of growth. These are problems that are pains associated with giving birth to sometimes a good idea that hasn't been fully implemented, and therefore, we're not sure of what's wrong and what's right.

But, I think from the testimony to doctors from HFCA, and all the other people that are involved in the system itself, show, I think, that HMO's are a very viable concept. The question is, How do you make them very, very strong?

How do you make them very strong? How do you make them work right so that: One, all the members of HMO's, especially those on medicare, because we're dealing with medicare beneficiaries, receive quality medical care without hassle, without a problem, and save money in the process for themselves, as one gentleman indicated, no deductibles, no copayments, et cetera, and no paperwork, and, two, how does the Government save money, which is your money too? You pay taxes for all these many years, and as a

result, we need a merging of those interests, and at the same time, have the Government do what is necessary to protect the elderly population of the United States.

These hearings are extremely helpful. I commend Mr. Mica again. He's been a leader in the field of trying to make sure that this kind of concept can grow properly and provide the health care that's necessary.

I am very grateful to you for allowing me the opportunity to be here today, and we're going to find the answers to these questions.

Mr. MICA. Thank you very much.

I thank my colleagues, all of the witnesses, and each of you for being here.

The committee is adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

APPENDIX

Congressman EDWARD R. ROYBAL,
Chairman, Select Committee on Aging,
House of Representatives, Washington, DC.

DEAR CONGRESSMAN ROYBAL: Congressman Rinaldo stated in the record, lines 1035 to 1045 that additional facts would be included in the records if submitted.

After Mr. Colavecchio made his statements lines 3090 to 3103, I said that they were *not true*, line 3104. I was not given the opportunity to explain my statement because of the limited time of the hearing.

I am now requesting that the following testimony be included into the record to give evidence of the lack of integrity of the character of Mr. Frank Colovecchio, president of Gold Plus HMO. I can provide documentation to prove that Mr. Colovecchio deliberately misstated the facts to cover up the mishandling of the patient.

3092—The hospital was told by the attending HMO Doctor Robert Robine to discharge the patient and sent home, because she required "costodial care." This was an incorrect evaluation because she needed "skilled care." She was unable to swallow food and was being fed by intravenous injection and finally needed "tube feeding" into her stomach, which can only be performed by skilled help, usually a doctor.

3093—The home care unit never came in.

3097-3099—It took several hours, and phone calls by Diane Kohl, of Cong. Mica staff, to the International Medical Center and the efforts of their executives, Mr. Jerry Atchison and Dr. Jay Sanders to persuade Mr. Colovecchio to order the doctor to have the patient returned to the hospital.

Line 3100—He did not bring HRS in Mrs. Slattery of Social Services of the Humona Hospital sent me down to their offices and she called Mrs. R. Albury to assist me. Unfortunately, the patient died before the HRS completed their evaluation.

Line 3101—The HRS was given documentation which showed that the financial status of the patient qualified her to receive their assistance.

Line 3102—It took over a week to place the patient into a nursing home. I tried to locate a nursing home which would accept the patient. I was unsuccessful because the nursing homes told me that their experience with Gold Plus HMO was very bad, and very difficult because of the lack of cooperation from the HMO.

3103—Mr. Colavecchio was able to place the patient into the Convalescent Center of the Palm Beaches because she now was correctly listed as requiring "skilled nursing care" and entitled to payment by Medicare. The Gold Plus provided the Medicare #056-05-5191A—HMO Authorization #550012C—to the nursing home. The patient died a few days after her admission.

I am enclosing a copy of the ads which appeared in many newspapers and magazines in Florida.

Please advise me if this information will appear in the record of the hearing. I would appreciate a copy of the completed testimony. I will be happy to serve your committee if you call upon me.

My thanks to you and your committee for trying to help make our "Aging" period easier to go through.

Sincerely,

DAVID CUSTAGE.

July 12, 1984.

DEAR CONGRESSMAN MICA: My wife and I attended the hearing on July 9th in Boca Raton of the House Select Committee on Aging at your invitation to my wife, Lily. You were much too occupied for us to present ourselves to you but I do wish

you to know that we were both impressed with the smooth organization of the meeting and your very effective direction of it.

Since we did not have an opportunity to speak, I am taking advantage of the procedure which allows my written remarks to be included in the record.

No one at the meeting touched upon what I consider an outstanding blessing of the HMO format for providing medical care, the liberation of the recipient from the paper work incubus. I have, unfortunately, first hand experience with this frustrating burden. My brother is an Alzheimer disease victim who has also had other medical problems which necessitated medical intervention repeatedly. During the last year he has been hospitalized five times, had surgery twice, required ambulance service ten times, received innumerable x-rays and other diagnostic procedures, literally hundreds of tests, nursing services, and services from a host of doctors—many of whom I had never heard and whose services to my brother remain a mystery to this day but all of them requiring telephone calls , letters, Medicare forms, supplementary coverage forms, resubmission of claims held to be incomplete or erroneous, etc. During the height of medical activity I had spent as much as three eight-hour days handling my brother's claims each week! Now the burden has dwindled to about 6–8 hours per week

Lest it be thought that the time I had to spend on his medical payments, claims and collections could be attributed to lack of familiarity with the procedures involved, let me state that I have had many years experience in my career dealing with medical insurance claims, Medicare, Blue Cross/Bule Shield, GHI, Kaiser Permanente and Connecticut General.

I cite my own problem only to highlight the burden imposed on recipients of medical care in the conventional formate most of whom are far less able to deal with the paper work than I. In my mind there is no doubt that many patients are cheated of their rightful reimbursements because they are unable to deal with the complexities of deductibles, exclusions, exceptions, documentation, and the fragmentation of responsibility for payment of claims between two or more reimbursing agencies.

I am very definitely in favor of HMO's as desirable alternatives to conventional medical care. They offer, however, only partial resolution of the problem of medical care. It is a very good first step but only a first step. What is needed is a complete, integrated health care system which combines the HMO with hospital and extended care facility—convalescent and nursing home. Not only would such a system do much to relieve anxiety and suffering but it would even be more economical than our current fragmanted care! The system proposed would eliminate billions of dollars now being spent for processing claims, processing individual payments, duplicating patient work-ups, etc. and could be sustained by the money saved.

Ultimately, and eventually, the the answer must be a national health care system based on need and ot the ability to pay.

Sincerely,

SAMUEL D. GORDON.

NORTH BROWARD HOSPITAL,
Pompano Beach, FL, June 28, 1984.

Representative DANIEL A. MICA,
Congress of the United States, Cannon House Office Building, Room 131, Washington, DC.

DEAR REPRESENTATIVE MICA: Thank you for your letter informing me about the July 9th HMO field hearing in Boca Raton. Your interest in investigating HMO's in this area is greatly appreciated by our hospital and the community.

As you know, Health Maintenance Organizations (HMO's) were established by Congress in 1973 to curb spiraling health care costs, while supposedly being able to provide quality health care services. However, while HMO's are an alternative to encourage health care cost containment, their quality and professionalism in our area is perceived by many local health care professionals as being highly suspect.

North Broward Medical Center has experienced many unprofessional practices by HMO's that have hampered the quality of health care delivery in our community. Recent problems include: 1) Lengthy delays in HMO payments to hospital physicians; 2) Long delays in receiving hospital admission approvals or disapprovals for critically ill patients, leaving some patients' conditions to greatly worsen; and, 3) False advertising by HMO's: most claim they are affiliated or have agreements with various hospitals when few are associated with any. Many enrollees want to termi-

nate their HMO agreement as soon as this practice is revealed to them, but feel they cannot due to a short term loss of all Medicare coverage.

Although Congress has given flexible treatment to HMO's to appease constituent complaints about increasing health care costs, these people are now beginning to scream for greater health care quality and assured coverage. This situation is intensifying as HMO clients on Medicare are realizing that they are not guaranteed hospitalization or proper care for serious medical problems that are common among the elderly. Most HMO clients are so petrified at the prospect of losing all Medicare coverage for 35 days or longer that they feel bound to their unsatisfactory and potentially life-threatening contracts. This problem has understandably left many of our senior citizens feeling helpless and hostile toward all health care providers and public policy makers.

The root of the problem is that HMO's have limited legal restrictions that make them much more financially oriented and motivated than hospitals. Without such restrictions, HMO's continue to make fiscal concerns their top priority. This attitude and practice has become evident in the many cases that continue to arise.

Enclosed are examples of HMO-related medical cases and problems that our hospital has experienced in recent months. Realistic, not panacea-type, solutions must be drafted by Congress to resolve these difficulties and to strike a balance between controlling costs and the need for quality health care.

Please contact my office if we can be of any further assistance to you in preparing for your important upcoming hearing. Thank you again for your attention to this critical matter.

Sincerely,

ROBERT L. KENNEDY,
FACHA Administrator.

Enclosures.

NORTH BROWARD HOSPITAL, POMPANO BEACH, FL

The following is a sample of the five HMO cases that the North Broward Medical Center receives on an average day. The names of specific people have been excluded to protect our patients. HMO company names do not appear as most are well represented. Also, at least two out of five HMO cases include people that want us to help them break their contracts immediately.

CASE NO. 1

In early June, an 82 year old woman was rushed to our emergency room by her daughter at 9:30 p.m. After numerous attempts, we finally made contact with the woman's HMO eight hours later. At that time, the HMO informed us and the family that the patient could not be treated at North Broward for her rectal hemmoraging. The woman was then sent to Miami General Hospital, which is an hur away, as it was the only facility approved by her HMO.

Problem: All HMOs should have 24 hour, 7 days a week, contracts and services, as do hospitals, to accommodate clients whenever accidents occur or treatment is necessary. Also, to avoid times lapses and ensure proper medical care, HMOs should be professionally and officially affiliated with several hospitals.

CASE NO. 2

In late May, a 70 year old woman was brought to our emergency room at 9:00 p.m. with a fractured hip from a fall. Three hours passed before her HMO informed us that she would have to pay for any services rendered by the Medical Center. That woman was finally allowed to be treated by the HMO the following day.

Problem: Same as in Case No. 1.

CASE NO. 3

In late April, a 68 year old woman on our third floor experienced renal failure and required immediate attention. None of her HMO physicians were available and the HMO said they would not pay for anyone else to see her. Both the Medical Center and the HMO tried locating an appropriate physician. Two and a half hours later a physician was found, but he could do nothing until the HMO authorization code was given to our staff.

Problem: HMOs must become more professionally organized and run to avoid delays in patient treatment, physician payment, and other general necessary services.

CASE NO. 4

I mid-May, a 78 year old man was brought to our emergency room at 9:00 p.m. His HMO's physician approved the admission and referred the case to another physician who scheduled the patient for surgery the next day. As the patient and physician prepared for surgery, the HMO informed us that their physician was wrong to admit the patient. The man was then rushed to Doctor's General Hospital, the only facility where the HMO would allow the patient to be treated. The family was outraged, as was the physician and our administrative staff.

Problem: Lack of professional and ethical medical accountability by HMOs, as well as a lack of communication not only with clients, but with physicians.

[From the Fort Lauderdale News, Mar 15, 1983]

HMO Upsets Hospital Officials

(By Gail Poulton, Medical Writer)

Miami.—Federal officials, anxious to keep a plan to save Medicare money afloat, faced 150 angry hospital administrators Monday over problems hospitals have with a Health Maintenance Organization involved in the plan.

"These kinds of things you're bringing up here are the kinds of things we're trying to understand before we go nationwide with a law that's going to affect everybody," said Dr. Bryan Luce, director of the Medicare office in Baltimore that developed the project. "We may not save money up front, but we're trying to see how we can save money in the long run."

The government is paying four South Florida HMOs 95 percent of what it would cost if their members were on Medicare. In turn, the HMOs provide routine medical care for their members and hospitalization when necessary.

Hospital administrators are upset over unpaid bills and refusal by International Medical Center HMO to pay what the hospitals consider reasonable charges.

"You thought you were coming to speak to a group—what you got was an angry mob," Julie Oldham of Southeastern Medical Center in North Miami Beach told the Medicare officials.

Once a Medicare patients joins an HMO in the federal project, he is obligated to get his medical care from the HMO or it must be authorized by the HMO, except in an emergency.

Ideally, hospitals have agreements to admit HMO patients. It works in other areas of the country, according to federal officials in charge of the project.

"This hasn't worked as well in the Miami areas as we would have liked," admitted Wayne Fowler, director of Medicare's group-plan operations division in Baltimore.

As far as the Medicare officials are concerned, these are inevitable wrinkles that have to be ironed out. But they are aware that those wrinkles could turn into mountains.

"It could torpedo the whole project if there were scandals and patients were hurt," said Luce. "That's why we're all down here and we're jumping in so quickly."

Only one hospital in Dade County and none in Broward has an agreement with IMC. Hospital administrators say the HMO will not pay them a fair amount.

"We have a study that shows the HMO patient costs 20 percent more than the regular Medicare patient," said Plantation General Hospital Administrator Al Quartin. "They don't put them in the hospital unless they're critcial."

He said because of that, more care is required, so the bill is higher.

The hospitals, who are obligated to admit anyone in an emergency, also say if IMC does not consider the admission a life-threatening emergency, it refuses to pay the bill.

The disputes have caused some hospitals to refuse patients who belong to IMC.

"They (IMC) don't appear to be concerned about the health of the patient. They are concerned with how they can get out of approving the admission and out of paying the bill," said Ms. Oldham.

The Medicare administrators offered the hospitals an alternative billing method they hope will solve the problem. If the hospitals don't want agreements with an HMO, they can admit its patients and bill Medicare directly, Fowler said.

"We're effectively giving the hospital a choice of how it would like to be paid," Fowler said.

Julio Avello, vice president for corporate development at IMC, said that should prevent hospitals from refusing to admit IMC patients.

"Now that they have the option they cannot turn the patients away," Avello said. "We're not unhappy with it and they shouldn't be unhappy with it."

As far as some hospital administrators are concerned, the change doesn't solve anything.

"It confuses it even more," said Lee Faulconer, chief financial officer of the North Broward Hospital District. "I don't think anything is going to change as a result of this meeting."

Faulconer said he is continuing to negotiate a standard agreement with HMOs for the district's three tax-assisted hospitals, but if they can't come to terms with IMC, they will bill Medicare for any HMO admissions.

Margate Hospital Administrator Hud Connery, who placed advertisements in community newspapers advising IMC members they are responsible for their own bills at his hospital, said that position has not changed.

"I'm just going to go ahead and bill the patient," Connery said. "I'm not very optimistic that in the near future any progress is going to be made."

Some hospital administrators, however, viewed the change more positively.

"At least it's a starting point, but there are a lot of questions that have to be answered," said Humana Hospital Bennett's Executive Director Ira Korman. "Somebody should realize they have to negotiate with the hospitals."

The hospital administrators' sentiments were not lost on the Medicare officials.

"The message is coming down loud and clear. If the beneficiary is being jerked around between the hospitals and the HMOs then they're not going to stay in the HMO and the demonstration won't succeed. A few people might get hurt by that but we'll learn a lot," Luce said. "The concept of HMOs is not going to go away—we've just begun."

[From the Miami Herald/Tuesday, Jan. 31, 1984]

Complaints Spur Probe Into Four S. Florida HMO's

(By Paul Anderson, Herald Washington Bureau)

Spurred by complaints from elderly constitutents, South Broward Congressman Larry Smith Monday called for a federal investigation of four pre-paid health-care firms in South Florida that accept Medicare patients under an experimental program.

Smith, in Washington, said he has asked the General Accounting Office (GAO) to look into the practices of the four firms, known as health-maintenance orgainzations (HMOs), including their advertising methods, the extent of their insurance coverage and the quality of care that they provide.

The Hollywood Democrat said, he also wants to GAO to look into the way the U.S. Health Care Finance Administration has monitored the rapidly growing programs since it launched the Medicare demonstration project in 1982.

The GAO has agreed to make an inquiry, officials said.

Officials with the Health Care Finance Administration and three of the four HMOs said Monday they have nothing to fear from an investigation.

Smith said he's not opposed to letting Medicare recipients go to HMOs, he simply wants to make sure that they are getting good care.

"I'm hopeful that this kind of program can work, because the whole idea is that we should be able to bring down the cost of health care while providing quality service," Smith said of the HMOs. " . . . But, based on the complaints we've been receiving, I suspect there are major technical defects in the way this system is working."

More than 72,000 Medicare recipients in Florida are enrolled in the four HMOs, according to figures that Smith's staff obtained from the Health Care Finance Administration. Three of the firms are based in Dade County: AvMed Health Plan, CAC Health Plan and International Medical Centers Inc. The fourth is Health Care of Broward.

International Medical Center is the largest, with more than 60,000 elderly people enrolled in its plan. About 18,000 of those enrolled in the last month, when International Medical Centers expanded in the Tampa-St. Petersburg area.

Avmed, which also offers it' plan in Tampa, has more than 6,000 enrollees, CAC has about 3,200 and Health Care of Broward about 2,000.

The principle behind an HMO is that a person makes monthly payments to cover any medical care he or she needs, whenever it's needed, at whatever cost. The Health Care Finance Administration allowed 60 HMOs around the country to begin enrolling Medicare recipients in 1982 in a demonstration project.

In South Florida, the average monthly payment per patient from Medicare is now about $232, according to Smith's staff.

The demonstration program first became controversial when some firms started mass advertising campaigns that described their plans as "government-sponsored," "government-backed," or "endorsed by the U.S. Government." A number of the firms, including CAC, were ordered to change their advertising.

The firms compete by offering services beyond those which Medicare normally covers, including such things as free or reduced eye-glasses, hearing aids and dental care.

Smith said he also is concerned about the quality of basic care that the HMOs provide, based on the complaints his office has received. Without naming the patients or identifying which South Florida HMO was involved, he gave five examples, including the story of a man who had trouble getting a prosthesis fitted after he had his leg amputated in January 1983. He was fitted three times by the same firm to which his HMO referred him, and all three times he developed sores.

The HMO refused to send him to a different fitter until Smith's office intervened after the man complained.

In most cases, Smith said HMO officials blamed the disputes on "administrative errors."

But he said he also has heard complaints about "ridiculous requirements" that HMOs put on their members, including at least one HMO that insists its members consult with its staff before seeking emergency aid, such as in the case of a heart attack.

"If you're having a heart attack, you must be able to get that emergency care. You can't take the time out to call your HMO before you call an ambulance," Smith said.

Dr. Sam Romeo, executive director of Health Care of Broward said his HMO is particularly careful to fully explain its program when it signs up elderly patients who may get confused, while others are growing so rapidly that they may not be as concerned. "We have a smaller plan and we're much more deliberate," Romeno said.

LAW OFFICES,
GIBBS AND ZEI, P.A.,
Fort Lauderdale, FL, March 30, 1984.

[Certified mail P514 748 043]

DEAR ———: Our firm represents the North Broward Hospital District, a special tax district of the State of Florida, which owns and operates Broward General Medical Center, Imperial Point Medical Center and North Broward Medical Center.

It has come to the District's attention that your organization is distributing literature for publication and solicitation purposes which identifies the three medical centers as "Affiliate Providers".

HMO has never obtained the North Broward Hospital District authorization to list the District's facilities as "Affiliated Providers". Therefore, your use of the District's facilities' names in your literature is unauthorized and the District specifically objects to this.

Demand is hereby made for the immediate removal of the District's facilities' names from any of your literature, publications and advertising and the immediate cessation of any distribution of any items that currently carry reference to the District or its facilities.

If your organization fails to immediately comply with the above demand, the North Broward Hospital District will seek injunctive relief and damages.

Sincerely,

WILLIAM ZEI.

DELRAY BEACH, FL, *July 7, 1984.*

Hon. DAN MICA,
House of Representatives,
E. Ocean Avenue, Boynton Beach, FL.

DEAR MR. MICA: I wish to register my discontent with the HMO (Delray Beach Atlantic Avenue).

When I joined, I was given a reasonably good examination and found to be in good physical condition. About a month after, I experienced a severe pain in the hip. I was pleased to receive an early appointment to see a staff doctor. He suggested x-rays of the hip. He advised me that the x-rays proved negative but gave me a potent pain killer.

After several weeks with no results from the medication, and having seen almost every doctor on the staff, I could not walk, I could not sleep and could not sit. On two occasions one of the doctors advised the director to refer me to an orthopedist. This was completely ignored, despite the fact that I had made many calls to the director concerning such referral.

I find that in their zeal to cut costs, they were derelict in the proper treatment of my ailment.

I have since disenrolled from the HMO and sought my own orthopedist, who has advised surgery. this leaves me in a bind because I find myself in limbo, without Medicare and Blue Cross coverage, which is a great financial hardship.

I hope this will help your subcommittee.

Very truly yours,

SAM LICHMAN.

ANTHONY NARDIELLO,
Coral Springs, FL, July 10, 1984.

Congressman DANIEL A. MICA,
131 Cannon House Office Building,
Washington, DC.

DEAR DAN: How nice it was to see you and your distinguished colleagues from the Select Committee on Aging in Boca Raton yesterday. I was really happy with the turn-out and it was a pleasure to see my old boss, Matt Rinaldo, once again. I had served as an intern in his office one summer during my college years.

I appreciated the committee permitting me to speak and I can understand how pressed for time you were. Surely, the audience was pleased with your handling of the hearing. Enclosed for the record is copy of a narrative I prepared detailing the type of care my late father received from International Medicare Centers. As you and your staffers read it I think you can see why I have no use or appreciation for IMC or the HMO concept. Please know that our of my father's $15,000 hospital bill the HMO refused to nearly $1,500. Letters to Mr. Recarey went ignored, the State Insurance Commissioner's Office was useless only Mr. Wayne Fowler got results. This took nearly $50.00 worth of phone calls but it got done. I had to call Mr. Fowler to get my Mom disenrolled as the local HMO was uncooperative, to say the least.

I noted the many comments concerning disenrollment and one of your suggestions was third-party intervention. While this may alleviate the problem it tends to add another layer of bureaucracy to that already there. I'd say it compounds the problem. Also, Dan, consider that the HMO receives a set number of dollars monthly whether or not it sees and treats patients. My father's HMO had 1,468 enrollees for which it received $100 per patient, totalling $146,800 income to the HMO. From that sum, the doctor must derive his salary, pay the help, rent and the patients hospital bills. My experience with human nature tells me greed will win out and the doctor would curtail necessary services to keep a larger share for himself.

Now you know why I detest the HMO concept so much and I am glad my Mom has returned to the conventional method of treatment. I hope you will include my comments and narrative in the official record and send my a copy of the committee's report when it is ready.

Sincerely yours,

Enclosure

ANTHONY NARDIELLO.

PREPARED BY ANTHONY NARDIELLO, SON OF ALBERT NARDIELLO

Patient: Albert Nardiello; Hospital: University Community Hospital, Tamarac.

IMC-HMO Physician: Pravin Patel, MD (Originally from Pittsburgh), 2929 North University Drive, Belle Terre East, Coral Springs, 33065, 755-0446, Eric Buchwald, Administration.

IMC-HMO Internal Medicine: Husman Khan, MD Belle Terre East, Suite R, 2929 North University Drive, Coral Springs, 33065, 753-5353.

IMC-HMO Neorologist: Alan Borenstein, MD, Suite 204, 3001 NW 49th Avenue, Lauderdale Lakes, 33313, 739-8484.

Second Opinion Requested by Family/Paid for by HMO? George Levy, Neurology, 7710 NW 71st Ct, Tamarac, 33319, 726-2025.

3rd Opinion Requested by and Paid for by Family: Carlos Singer, MD, Suite 210, 7301 N University Drive, Tamarac, 33319, 722-0012.

Dr. who preformed Arteriogram Nov 81 in University Hospital: Ing-Sei Hwang, MD, 4701 N Federal Highway, Suite A-25, Fort Lauderdale, 33308, 771-3240.

Patient joined IMC on 10-27-82 with membership effective 12-1-82, originally Fort Lauderdale Medical Center, 4300 West Oakland Park Boulevard. Was given several blood tests on 11-11-82 (see copy)

Patient learned of Tri-City Medical Center via ad in local paper (see copy) and transferred membership there. (Tri-City and Dr. Patel same address and phone.)

Approximately late Nov/early Dec '82 patient complained of difficulty in hearing and want to Patel for treatment. Patel flushed patient's ears with some solution using large stainless steel syringe. Patient could hear better in right ear although left ear showed no improvement. Patel permitted son to examine ear with lighted instrument which revealed a scab-like lesion on ear drum. Patient complained of dizziness but Panel insisted this would stop soon.

Mid Dec '82 patient becomes violently dizzy, nauseous with much vomitting. Patel makes houses call, makes cursory exam. (no temp taken) and diagnoses condition as "a virus." Gives patient an injection of something for dizzyness and gives blue-white pills as well. Pills come in unmarked envelopes and no receipt was request.

Patient remains ill for two weeks, family feels patient should be hospitalized. Patel sez this is not necessary. Patient recovers, sees Patel in office who pronounces him well.

Between Jan 1 '83 and Easter Sunday, April 3 '83 patient saw doctor itermittently for blood pressure checks and prescription refills. I cannot remember any blood tests, EKG's or other diagnostics tests taken during this period.

During this period patient still complained of lower level of hearing in left ear. Patel used ear device, showed son that scab, he called it "clot" was still on left ear-drum. Patel chose not to investigate further but prescribed the use of corn oil drops to be used in ear at the rate of 1-4 drops daily. Son did this be means of a plastic syringe. Patel advised this was to loosen clot away from ear. Patient's hearing did not improve but Patel insisted on continuing this treatment.

Patient becomes ill on Sunday Morning, April 3, Easter. Patel is called and told of sypmtoms that are similar to Dec. '82. He does not examine patient but askes son to pick-up pills at office. Patel feels it's the same problem, "A virus." Son is again given blue-white pills and yellow one as well. Yellow one is not clearly labeled. Patient also complained of neck pain Patel said it was ok to use heating pad.

Approximately noon patient has problem with distortion on left side of face and family calls in paramedics. Medics arrive shortly, although policeman arrives first. Patel arrives last minute and administers treatment to patient. Patel promises a neurologist.

Patient is taken to Community Hospital at Patel's request and arrives in Emergency Room and is then taken to Trauma Room. At this point patient is still talking coherently. During this period son is at ER admitting desk. When he informed admitting clerk that this is an HMO patient, clerk threw down HMO cards and got up in disgust. She informed son, in so many words, what a paperwork chore this was and went to call HMO in Miami HQ to get permission for treatment. This took nearly 20 minutes. During this period it looked as though patient was receiving NO treatment while hospital waited for treatment permission. Permission was granted but no neurolgist was in sight. Hospital then needed further permission for admitting, son had to get on phone to HMO HQ in Miami; nearly 40 minutes passed for this permission to be granted and it still appeared as though patient was neglected. Again, no neurologist was made available.

Patient is transferred to semi-private room, 102 and receives some cursory examines by male nurse and an IV is set up. Patient is given meal which family helps him to eat. Shortly after patient vomits meal and male nurse phones doctor. Late that afternoon Dr. Khan, Internal Medicine, arrives, makes examination and says patient will be dead soon or words to that effect and walks away.

Patient's condition deteriorates in early evening and he is transferred to ICU, Room 8. Condition fell as evening wore on as patient could not control limb movement. Son and mother engage in tirade with Laverne the nurse as to why nothing is being done. Nurse escorts us away from desk, calls Khan. She angrily tells him that patient needs a neurologist and family is angry as to why one was not assigned.

Dr. Borenstein does not arrive until midnight for examination. Blood gases were checked that night but results were delayed as technician botched up procedure and had to do it again, took additional 20 minutes. Borenstein could not ID yellow pill. My sister and I went to several pharmacies who also could not ID yellow pill. Borenstein is again queried about yellow pill and suggests it be sent to hospital pharmacy. Hospital pharmacy refuses to do this procedure and says it "doesn't want to get involved in the middle of things."

Family wishes Khan, because of his attitude dismissed from case. Patel is telephoned and refuses to return calls. Khan askes for a family meeting attended by son and both sisters. Khan gives us a long lecture on Medicare costs and says we have three options.

(1) get another opinion
(2) stay with me
(3) get me off the case.

Khan mentions possible use of respirator, advises against it due to costs. Son firmly tells Khan to use it and any other means necessary to sustain patients life. Khan reluctantly agrees. Son calls Miami HQ speaks with Mr. Ramirez requesting that Khan be removed from case. Ramirez says this is not possible and Khan must stay on the case whether we like it or not.

Family requests 2nd opinion to be paid by HMO. Dr. Hwang recommends Dr. George Levy. Family later requests 3rd opinion by Dr. Carlos Singer paid by the family. HMO local administrator Eric Buchwald says Singer can examine but only Khan can approve tests or treatment. Khan has patient transferred back to regular room, 114; family felt this was premature but their objections were not given an audience. Questioned Borenstein on move who says its a question of money that he be moved. Also questioned Borenstein on physical therapy said patient was receiving it.

Patient received sloppy IV insertions as tubes had small air bubbles in them. Informed nurses who said this was ok. Patient did not receive same level of treatment and care as in ICU and feel this contributed to his demise.

Khan recommends food tube be inserted thru stomach for long term care. Surgery scheduled for Fri April 15. Patient has heart problems morning of 15th and expires. Khan is not around.

Should be noted that patient was shuttled to and from hospital to Florida Medical Center periodically for CAT scans. Located at 5000 West Oakland Park Boulevard, Lauderdale Lakes.

Mom disenrolls from HMO May 19, Thursday and Patel calls me and says:

(1) Do not come to this office again with your bills or there'll be trouble. Adm. said it was perfectly all right to bring bills in person to office.
(2) Says I didn't appreciate what he did for my father.
(3) (our house is for sale) Says we will never sell our house in this market.
(4) Implied I was a bum for not working, I'm presently on leave of absence.
(5) Said I was a poor Catholic for not being in church that past Sunday.
(6) Said we do not have enough money to sue him and he's not worried.

Son called Ramirez at HMO HQ who said trouble with Patel occurred before and local adm. Buchwald handled it. Said he would check into this matter for me.

Family feels:

(1) Total lack of interest in my Dad's case and condition.
(2) Misdiagnosed early warning stroke signs back in Dec. * * *
(3) Withheld or curtailed or diminished treatment that would have enhanced patients chances.
(4) Step 3 was taken to save HMO money without regard for patient.
(5) Patel made cursory exams of patient since beginning of membership in order to save HMO money.

BEST BUY DRUGS, INC.,
West Palm Beach, FL, July 11, 1984.

Hon. DAN A. MICA,
639 E. Ocean Avenue,
Boyton Beach, FL.

DEAR DAN: I found your hearing on HMOs held in Boca Raton interesting and informative in areas of patient care, but lacked coverage of the impact HMOs have on the business community.

Many small businesses, such as ours, have been totally shut out of participating in the programs now in the area. We neither hear about nor are allowed to bid to provide pharmacy services to the members of the plans. Programs such as Mr. Colavecchio's and Family Practice Center's, for example, respond neither to our letters nor our phone calls. It appears that our own tax money is being used in an attempt by the Government to put us and other small companies out of business.

In a community such as Palm Beach County, with its large proportion of elderly, we see a steady erosion in the number of prescriptions as the HMOs push to enroll new members. Others in our field and specialties, such as opticians and dentists are also noticing a declie in volume.

It is one thing to be allowed to compete and fail, but not to be offered the opportunity, especially when the funds are from the Government, is totally unreasonable. Logic tells that free and open bidding should provide better and less expensive services to the recipients.

Failure to solve these inequities may force the small business community to sue the Government for antitrust violations.

Thank you for the opportunity to express myself and feel free to enter my comments into the records of the HMO hearing.

Sincerely,

ROBERT F. PICKETT, *President.*

SEYMOUR R. ROSEN, M.D.,
Sunrise, FL, July 13, 1984.

Hon. DAN MICA,
Cannon House Office Building,
Washington, DC.

DEAR CONGRESSMAN MICA: I am writing this both in response to your letter of June 9 inviting my opinions on health care issues of national concern as well as your statement made on July 9 in Boca Raton in which you left the Congressional record open for 7 days for additional audience comments; accordingly please include my letter as well as the enclosed statements from two patients a part of this Congressional record.

In contrast to the statements of my medical colleagues made during the House Select Committee on Aging July 9 I do not feel that HMO's are either desirable or inevitable. I do agree completely that cost savings must be achieved but I feel that the private practitioners of medicine are best able to make these changes while ensuring quality medical care at the same time. A system in wich a buisnessman-entrepeneur is running the HMO is destined to result in abuses and inferior medical care because the bottom line will always be his own profit—and if profits can be maximized at the patients expense than that cold business decision will be made. The many abuses that were alleged by the president of the Palm Beach County Medical Society and others are merely barometers of what might happen if this system is expanded. I know that you agree that such abuses must be corrected, and the sooner the better. I can tell you that I have first hand knowledge of the fact that I.M.C. HMO representatives are soliciting customers in some black areas and elsewhere, especially in Pompano Beach, and enticing some of the elderly citizens to sign up with promises of free care. Some of these individuals can not read or write and certainly cannot comprehend the ramifications of what they are getting into. Of course they are never told that they can't go to their local hospital or physician, and that the center they may have to go to can be many miles away. I am enclosing letters from two such individuals who were enrolled by I.M.C. only to withdraw once they discovered the disadvantages of what they had done. Clearly, tighter regulations are needed to prevent such abuses.

What can the Federal government do to realize significant savings in its health care costs without sacrificing the quality of this care? This Congressman Mica is the crucial question. I maintain that the private patient-doctor relationship, which has been the conrnerstone of the high quality medical care system in this country must be preserved, in order to maintain current standards. My suggestions for reducing health care costs are as follows: 1. The federal government should refuse medicare reimbursement to any hospital or other health care facility that is built where state and local health care planning staffs have determined, using uniform guidelines to take into consideration possible regional differences such as percentage of the elderly and projected population growth, that they are not needed. 2. In order to accomplish savings similar to what is expected of an HMO, i.e., 5% of the usual per patient medicare expenditures, hospital admission criteria should be based strictly on the regulations that guided the previous government funded PSRO system which was recently discontinued in Broward and many other areas of the country. Most importantly, such review should be carried out before the patient is allowed admission, except of course that there would be no delay in admission and the review would be instituted after admission if the admitting physician certifies that such admission is a life threatening medical emergency. This hospital admission utilization review shall be carried out by a group of physicians appointed by the hospital medical staff. The hospital shall be required by the government to reduce its admissions and hospital days by at least 10% over those of the preceeding 12 months. If such hospital utilization review fails to achieve the required savings than that hospital

shall have an appropriate amount of medicare funds with held to attain the same dollar savings. 3. Incentives for outpatient surgery should be increased; a good start in this regard has already been made by the government in increasing payments to physicians doing outpatient surgery on an assignment basis. It is expecially noteworthy that the country's ophthalmologists have been pioneering outpatient cataract surgery and this is already saving the government millions in medicare funds.

I would like to present to you a classic example of how a political system can contribute significantly to excessive health care expenditures: Here in Broward county it was established several years ago by both the county and State Health Planning Councils that additional hospital beds would not be needed until 1990, even taking into account projected population increases. This however, did not suffice to prevent the issuance of certificates of need to the North Broward Hospital District for an additional 272 beds—while correctly denying such certificates of need to other private hospitals in the county. This has resulted in the county borrowing 90 million dollars, 40 million which will be spent on a completely unnecessary hospital. You can imagine the huge waste in federal funds that will result from the over-utilization of a facility that didn't need construction in the first place. So the fly in the ointment so to speak in the argument I am presenting to you is that until politicians, yourself included—you represent the northwest area of Coral Springs where the 200 bed hospital will be built—can speak out against waste in health care wherever it may occur significant cost savings will not be achieved. From the newspaper clippings enclosed you can see for yourself that I have already taken in public a position that others would not dare to take. The American public demands no less from all its elected officials. My interest in this matter is my strong desire to achieve quality medical care in a cost efficient manner. I sincerely thank you for receiving my comments and I hope that they will be helpful to you in your continuing constructive efforts to help the system.

I am,

Yours truly,

SEYMOUR R. ROSEN, M.D.

Enclosure

POMPANO BEACH, FL, *July 10, 1984.*

DEAR SIR: I would like to tell you about my experience with an H.M.O. A lady came around my neighborhood telling me and others we could get free health care and other good things. She did not say that I had to give up using my own doctors. Also, I did not know that I had to go so far away to visit the H.M.O. doctors. When I got a very bad eye problem I was told I had to wait 3 months to get an appointment. Because of this I had to get out of the H.M.O. I feel I was lied to and not treated very good and if I knew what it was really all about I would never have gotten in the first place.

GEORGE HUDSON,
International Medical Centers.

POMPANO, FL.

I went to the cheese site to get the free cheese and a lady came up to ask me if I wanted to join the HMO. Actually she asked for my medicare card. Since I had a medicaid card and had just received my medicare card, and had no idea what it was, I showed the medicaid card. She asked if I had the other one and I gave it to her. She told me all the things I could get without explaining that I could not go to my doctor if I joined. Since this was a government site, for the cheese, I thought that this was a government run thing and I could still go to my own doctor. She talked so much that I got confused and nervous and joined. I then found I could not go to my doctor because he did not belong.

I asked for a disenrollment form and sent it in. They said they did not get it so I sent a copy. They now say I cannot get out until August and since I sent it before the disenrollment date for July I do not think this is fair.

ELLA M. JOHNSON.

PALM BEACH HEARING AID SERVICE,
West Palm Beach, FL, July 9, 1984.

Congressman DAN MICA,
131 Cannon Building,
Washington, DC.

DEAR CONGRESSMAN MICA, I wish to bring your attention to a matter regarding health maintenance organizations which I think would pertain to any decisions that will be made in the future regarding their effectiveness and desirability.

I was recently approached by a representative of the Av-Med Health Plan asking me if I would be interested in being their representative for hearing aid dispensing in the Central and Northern Palm Beach County areas. I explained to her at that time that my information regarding HMO's and hearing aid dispensing suggested that they were looking for dealers who would provide extremely inexpensive hearing aids at a flat rate of about $75.00 per patient. Furthermore, since decent hearing aids cost the dispenser much more than that, the reason such a dealer would wish to participate would only be to secure referrals from the HMO and sell those patients proper hearing aids at a higher price because the cheap one would be of an obviously undersirable appearance, or quality, etc. The Av-Med representatives assured me that in no way was this their method of doing business.

On paper their proposal looked as though she might be right. They indicated that they would provide funds to cover the cost of the hearing aid, a dispensing fee, a fee for earmolds, and other ancillary reimbursements. When analyzed it looked very much like the Medicaid program we have here in Florida. The participant would be expected to pay a $100.00 co insurance fee plus $5.00 per office visit.

When I got deeper into the negotiations I found that in fact they were looking for special discounts on my part and the co-insurance to be paid to them so that when everything was totaled and subtracted the bottom line figure which I would be paid to dispense these hearing aids turned out to be $75.00.

In Av-Med's advertising they attract patients in part with the assurance that their hearing aid needs will be taken care of. When the patient walks into the hearing aid dispensers office, he is shown a piece of junk which very few will want, and is then talked into a hearing aid for which they must pay themselves. We have a complicated and professionally clouded bait and switch advertising scheme which has been illegal for years.

I should hope you and anyone in Washington interested in the subject of HMO would want to take a long look at this aspect of those plans and do something about it. To that end, if I can ever be of any assistance you have only to contact me.

Thank you very much for your efforts.

Very truly yours,

DAVID R. VREELAND, M.A.

E. WAGNER,
Lauderhill, FL., June 23, 1984.

DEAR CONGRESSMAN MICA: I understand you will be holding hearings on HMO's, I would like this read into the record.

On January 20, 1983 Milton Paushter had blood test and chest X-rays done at the Community Medical Center 7301 No. University Dr. Tamarac. He was never told the results of either and when he went on 2 subsequent visits, once for pains in his toe and another time for athletes foot which didn't clear up.

At not time was the blood test repeated although the duplicate copy we requested recently stated that it should be repeated on the next visit (I am enclosing it).

When he had trouble getting on appointment because they were so busy, he switched to the Southern Community Medical Centers Inc. at 2197 N.W. 53 St. Tamarac. He was examined there last month and his blood test revealed he had polycythimica which is a contributing cause to the condition he has now.

He is very ill and is now a patient at Imperial Point hospital where he has undergone 4 major operations because of a circulatory condition which should have been treated when his blood test on January 20, 1983 revealed his problem. He will have to have his foot amputated when he is strong enough.

HMO's are a great concept but when patients lives are put in jeopardy because some centers are two busy for follow up, controls should be established.

I trust your committee will succeed in correcting the abuses of HMO's.

Sincerely,

Mrs. EDITH WAGNER.

QUALITY LABORATORY SERVICES, INC

Phone: (305) 620-6730
Broward Phone: (305) 962-3199
Medicare Number 10-8222
Florida License Number 800000631

PATIENT INFORMATION	LAB NUMBER	DATE DRAWN	ACCOUNT INFORMATION
LSMITER	A00[illegible]020	[illegible]-19-93	[illegible] COMMUNITY MEDICAL CENTER [illegible] 301 SW UNIVERSITY DR. PEMBROKE, FLA.
[illegible] 0308	ANALYSIS DATE 01 [illegible] DT# [illegible]		ATTN DR. [illegible]

TEST NAME OR PROCEDURE	RESULT	ABNORMAL	NORMAL RANGE	UNITS
[illegible] BLOOD COUNT		11.24 H	4.8-10.8	X 10/3
D BLOOD COUNT	5.38 NEEDS TO REPEAT CBC next visit (Having U.S.)		4.7-6.1	X 10/6
[illegible]GLOBIN		21.4 H	14.0-18.0	g/dl
MATOCRIT		52.8 H	42-51	%
V		98.2 H	80-94	cm3
H		39.7 H	27-31	pg
[illegible]		40.5 H	33-37	g/dl
UTROPHILES	60.4			%
[illegible]OCYTES	27.5		15-40	%
NOCYTES	4.7		0-10	%
[illegible]TROPHILES	4.3		0-7	%
SOPHILS	0.2			%
	0.9			%
ATELETS	468		140-440	X 1000
ALYSIS				
[illegible]	YELLOW			
EARANCE	CLEAR			
[illegible]AVITY	1.020		1.005-1.035	
	6			
[illegible]	NEG			
GAR	NEG			
[illegible]	NEG			
LE	NEG			
[illegible]GLOBIN	NEG			
C	N			
C	0-1			
CTERIA	NEG			
ITH	[illegible]ONS			
[illegible]ORPH	OCCASIONAL			
[illegible]	NONE			
STS	NONE			
[illegible]	NONE			
[illegible]				
UCOSE	83		70-125	MG/DL
LESTEROL	194		120-330	MG/DL
IGLYCERIDE	132	ON DIURETIC	30-172	MG/DL
[illegible]	2.5		2.3-9.0	MG/DL
N		27 L	10-26	MG/DL
[illegible]NINE	1.3		0.7-1.4	MG/DL
	*** FINAL REPORT ***			

308

ALITY LABORATORY ASS IATES, INC

[illegible] HOLLYWOOD BLVD
HOLLYWOOD, FLORIDA 3021

Phone: (305) 920-0730
Fax: Phone: (305) 962-3199
Medicare Number 10-8222
Florida License Number [illegible]

PATIENT INFORMATION	LAB NUMBER	DATE DRAWN	ACCOUNT INFORMATION
[illegible]	[illegible]	[illegible]	COMMUNITY MEDICAL CENTER 2301 NO. UNIVERSITY DR. [illegible], FLA.
[illegible]	ANALYSIS DATE [illegible]	214	
	REC. [illegible]		

TEST NAME OR PROCEDURE	RESULT	ABNORMAL	NORMAL RANGE	UNITS
[illegible]	31		5-40	MU/ML
[illegible]	47		7-40	MU/ML
[illegible]		294 H	100-225	MU/ML
ACID PHOSPHATASE	74		50-155	MU/ML
[illegible] BILIRUBIN	0.8		0.2-1.2	MG/DL
	*** FINAL REPORT ***			
	RTE 001 86			

[illegible]

LAKE WORTH, FL, *July 12, 1984.*

Hon. DAN MICA,
Cannon House Office Building,
Washington, DC.

DEAR MR. MICA: Here is what I tried to tell you in one (1) minute at the hearing you held in Boca Raton last Monday, July 9.

Before you add it automatically to the record, I beg that you read it yourself.

With all good wishes.

ALBERT V. WHITEHALL.

Enclosure

HMO IDEAS ARE 70 YEARS OLD

(Albert V. Whitehall)

When Congressman Gephart of St. Louis introduced his Kennedy-Gephart Bill in February 1984, he observed that: "St. Louis has almost twice as many hospital beds as Seattle, and St. Louisans use the hospital twice as much."

Doctors in the State of Washington do things differently. Every county medical society has a prepaid health care program. Their basic features are much like Health Maintenance Organizations as we know them today.

It all began before World War I. Lumber companies were harvesting the vast redwood forests of the Northwest. Companies brought in contract doctors to care for injured loggers. Doctors were disturbed by the competition, of course. More important was the fact that the companies did not provide care to dependents. Families were coming into doctors' offices as charity cases.

In 1912, in Tacoma, the Pierce County Medical Society set up the first prepaid health care plan. Nearly every other county medical society in the State soon followed. When I came to Seattle as Executive Director of Blue Cross, in the mid-fifties, medical society health care programs had evolved to a pattern that was about like this:

For a monthly premium, doctors offered total medical and hospital care to every subscriber and his family. Premiums were put into a pool, from which hospitals were paid, usually at cost from non-profit hospitals, and doctors were paid about 75% of their usual fees. At the end of the year, funds in the pool were distributed to doctors as a year end "bonus".

It didn't take doctors long to recognize that abuses of hospital care, such as unnecessary hospitalization, unnecessary surgery, etc. could reduce the pool and jeopardize their year end bonus. Doctors began to watch each other. The result was a savings in hospital care—the most costly component of health care—and there was a notable improvement in the quality of care. The financial incentive was the key factor in self-policing by doctors.

In our traditional fee-for-service system, financial incentives for quality and economy do not exist. The rewards of medical practice too often come from the opposite direction. It has been the surgeon who found the need for surgery for which he would collect a fat fee. (That's why second opinions are so desirable). There's been too much pressure on doctors to put the patient in the hospital because it's easier to treat him there.

If the people of the State of Washington can survive with half the amount of hospital care, why can't we? It's the hospitals that cost money; but it's not the doctors' money!

Regretfully, it's not the doctors who are promoting HMO's in South Florida. The Federal Government is paying corporations to do it for 5% less than it has been costing Medicare to do it. How do these corporations expect to make profits? By keeping you well, and keeping you out of the hospital unless real need is shown.

Doctors in the State of Washington discovered the principle of HMO's—70 years ago. From what Mr. Gephart says, it still works.

○